guidelines for

INVOLUNTARY CIVIL COMMITMENT

NATIONAL CENTER FOR STATE COURTS

A Project of the Institute on Mental Disability and the Law National Center for State Courts

The *Guidelines for Involuntary Civil Commitment* is a project of the Institute on Mental Disability and the Law, which was established in 1981 by the National Center for State Courts as part of its Division of Research and Special Services. In creating the Institute, the National Center for State Courts acknowledged the increasing importance of mental disability law issues in the administration of justice.

A subcommittee of the board of the National Center for State Courts, chaired by Chief Justice Robert N.C. Nix, Jr., of Pennsylvania, oversees the Division of Research and Special Services, under which the Institute functions. Other members of the subcommittee are Chief Justice William G. Clark of Illinois; Judge Harriet P. Henry of the District Court of North Windham, Maine; and Mr. Stanley R. Collis, Executive Officer of the Alameda Superior Court, Oakland, California. In addition, a board of advisors consisting of specialists meets regularly to offer expert counsel to the staff of the Institute. Its members (listed on page 95) are broadly representative — judges, directors of state mental health departments, court administrators, scholars in mental health law, psychiatrists and psychologists — and well equipped to guide Institute activities in ways that are responsive to the needs of state courts.

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PREFACE

The pain and anguish endured by the mentally ill and their families are of concern to mental health professionals, attorneys, judges, social service providers, law enforcement officers, advocates, program administrators, legislators, and citizens. This guidebook is intended for use by all who are involved in the development of policy, the planning of programs, and the administration of the involuntary civil commitment process. An aim of the National Task Force on Guidelines for Involuntary Civil Commitment in formulating the guidelines in this volume was to be sensitive to the therapeutic needs of the person alleged to be mentally ill and to facilitate the development and use of fair and workable procedures for involuntary civil commitment.

A distinguishing feature of this guidebook is that it eschews the confines of the conventional debate about involuntary civil commitment characterized by narrow disciplinary concerns and divisive controversy. Although it may be impossible to consider the involuntary civil commitment process without confronting sharp differences of opinion and conflicting attitudes about mental illness and society's responsibility to alleviate suffering, the guidebook is premised on the notion that the goals of helping people and protecting their liberty are not necessarily contradictory. A system of involuntary civil commitment will be valued to the extent that it can accomplish both goals. Because of the need for treatment of mentally disordered persons and because of society's duty to respond to that need, some may value a system that can easily provide treatment and care even if there must be coercion. Others value a system to the extent that it can protect individuals from deprivation of their liberty. For many years, the rigid and extreme positions of various individuals and groups concerned with involuntary civil commitment have all too often led to exacerbation of differences, polarization, and alienation. As a general principle, the guidebook assumes that sound therapeutic objectives and the protection of legal rights are not incompatible.

It is expected that not everyone will embrace this volume in *toto*. Every jurisdiction need not accept all of the guidance given, and one would hope that such is not necessary. Some concepts and procedures contained in this guidebook may have to be modified to accommodate local concerns. It is hoped that, at the least, the guidelines will serve as a catalyst for debate and constructive change.

This guidebook owes its existence to three principal factors: the generous financial support of the John D. and Catherine T. MacArthur Foundation, the contributions of the individuals who formed the National Task Force on Guidelines for Involuntary Civil Commitment, and the hard work of the staff of the Involuntary Civil Commitment Project, under the leadership of Ingo Keilitz, director of the Institute on Mental Disability and the Law, National Center for State Courts.

The support of the MacArthur Foundation is gratefully acknowledged. William T. Kirby, vice-chairman and general counsel of the MacArthur Foundation, deserves special thanks for his continued strong interest in the area of involuntary civil commitment and his vision of the project as an important contribution to the rule of law and its relationship to the mental health system.

The members of the National Task Force (their names and affiliations appear immediately preceding this preface) contributed countless hours, sage advice, and, ultimately, the recommendations and suggestions set forth in this guidebook. They did not always agree. Considering their diverse views, it is remarkable that they did not disagree more often. The National Task Force made cooperation, not confrontation, its *modus operandi*. The members recognized that even the strongest supporters of commitment are not unconcerned with the rights of mentally ill individuals and that most supporters of stringent legal safeguards are not lacking in compassion for persons afflicted with mental illness. Although the meetings of the National Task Force were always characterized by lively debate, in the end, agreement about the underlying premises of this guidebook was achieved.

There are a number of individuals, known throughout the project as "invited observers," who regularly attended the meetings of the National Task Force or contributed significantly to the composition of the guidelines and commentaries. They served as *de facto*, if not official, members of the National Task Force. It is with gratitude that I acknowledge them here: John Ambrose, manager of public policy, National Mental Health Association; Richard J. Bonnie, professor of law and director of the Institute for Psychiatry, Law and Social Policy, University of Virginia; Janet L. Coye, Hawaii Department of Health; Donald H.J. Hermann, professor of law, DePaul University; Richard Lynch, project director, Criminal Justice Mental Health Standards Project, American Bar Association; John Parry, editor, *Mental and Physical Disability Law Reporter*; and Saleem Shah, chief, Center for Studies of Antisocial and Violent Behavior, National Institute of Mental Health.

In addition to the work of those directly connected to the National Task Force and the Involuntary Civil Com-

mitment Project, the efforts of a great many individuals and organizations — too numerous to mention them all — have contributed to the research, writing, and editing of this guidebook. In the early stages of the Involuntary Civil Commitment Project, staff received guidance from a group of individuals known collectively as the National Advisory Board. The individuals in this group helped to frame and resolve major issues of substance, research design, and presentation of results in the early stages of the project. With the exception of three individuals, this group formed the core of the National Task Force. Although their affiliation with the Involuntary Civil Commitment Project ended before the work on this guidebook began, the contribution of the following individuals was significant in the formative stage of the project: Helen Wright, past president of the National Association for Mental Health; Paul Friedman, attorney with the law firm of Ennis, Friedman, Bersoff and Ewing; and Floyd E. Propst, judge, Fulton County Probate Court, Georgia. I thank them for their help.

Both present and past members of the staff of the Involuntary Civil Commitment Project labored hard and long to make this guidebook possible. Without them, it would not have seen the light of day. Past staff members who deserve special thanks are W. Lawrence Fitch, Lisa Russell, and Joel Zimmerman. The staff, management, and Board of Directors of the National Center for State Courts are acknowledged for their contributions in making the Involuntary Civil Commitment Project possible. Edward B. McConnell, executive director of the National Center, originated the project concept. Members of the National Center's Board of Directors reviewed the project and commented on it from the perspective of judges and court administrators. Library staff provided enormous aid in locating and acquiring reference materials throughout the project period. Finally, the staffs of the National Center's Publication Department and the Word-Processing Center provided invaluable support that made the publication of this guidebook possible.

As chairman of the National Task Force, I extend my personal appreciation and that of the other members of the National Task Force to the project director, Ingo Keilitz, for his outstanding contribution. He brought to the Involuntary Commitment Project a rich background in the behavioral sciences along with a thorough understanding and appreciation of the law. His skillful administration, his capacity to stimulate thoughtful research, and his resolution of difficult issues are reflected throughout this guidebook.

Judge Joseph Schneider
Chairman

INTRODUCTION

Involuntary civil commitment is the legal, medical, and psychosocial process whereby a person deemed to be mentally ill and dangerous to self or others and in need of treatment is forced into involuntary mental health care. The ways in which this authority is exercised reflect different combinations of legal criteria, which establish the situations and characteristics of persons subject to commitment,[1] and important duties of the state, including the police function of protecting society and the *parens patriae* function of protecting the individual.[2] Today, involuntary civil commitment is usually the last resort of family members, law enforcement officers, mental health and social services professionals, and judicial officers for providing treatment and care to individuals who are either unwilling or unable to receive such service voluntarily. Few exercises of governmental authority engender as much controversy and debate as involuntary civil commitment.

At the heart of the controversy are questions about the proper balance between the need for legal safeguards against improper commitment -- which may delay and complicate treatment -- and the need to allow mental health and social services professionals sufficient discretion and autonomy in their decisionmaking -- which may endanger the civil liberties of involuntary patients. What should be clear is that a perfect balance between the interests of the individual, the family, the community, and the government in involuntary civil commitment may not be possible, because the process implicates competing moral values, political ideologies, and different approaches to decisionmaking.

A Perspective

Over the last thirty years, American society has leaned alternately toward one side of the balance or the other, first giving mental health professionals wide latitude in initiating involuntary mental health care and then favoring stringent legal safeguards and restrictions on the civil commitment process.[3] During the 1950s, it was relatively easy for police officers, families, and mental health professionals to accomplish commitment and rid themselves of the burdens associated with the care of mentally ill persons. Commitment laws were lax, and great power and discretion were vested in the medical profession to "warehouse" mentally ill persons in public asylums with inadequate professional staff, little or no treatment, and deplorable living conditions.

Beginning in the 1960s, as the plight of mental patients became a civil rights issue, the balance tilted dramatically toward the protection of civil liberties of involuntary mental patients, and restrictions were placed on the discretionary authority of mental health professionals and family members to commit mentally ill persons indefinitely to large, state-run institutions. At about the same time, profound changes in the care of mentally ill persons were occurring that made long-term involuntary hospitalization unnecessary for many patients: the widespread availability of new drugs, making outpatient care more feasible; the movement toward deinstitutionalization and the implementation of the theory of community mental health; and the introduction of Medicare, Medicaid, and Supplemental Security Income (SSI), providing alternative sources of payments and economic incentives for human services outside of public mental hospitals.

During the 1960s and 1970s, aggressive advocacy on behalf of mental patients' civil rights led to the widespread adoption of legal safeguards in involuntary civil commitment laws resembling the due process guarantees of the criminal justice model. Among these were the threshold requirement that a person be dangerous before he or she may be committed, the right to notice, access to legal representation during all phases of the commitment proceedings, the right to a judicial hearing to challenge the initial commitment, determinate and relatively brief commitment periods, and the right to mandatory periodic reviews of continued involuntary commitment. Some states recognized rights of involuntary patients to a jury trial in civil commitment proceedings, to an independent mental health examiner to check suitability for commitment, to refuse to answer questions posed by examiners employed by the state or the court, and to be placed in the "least restrictive alternative" facility or program of care. By the mid-1970s, many states had enacted restrictive laws that contained narrow commitment criteria and stringent legal safeguards. These laws made it more difficult to commit persons deemed mentally ill and in need of treatment.

By the early 1980s, there were signs that the balance had begun to tilt again toward a relaxation of restrictive commitment laws. Some observers came to believe that the legal safeguards against improper commitment based on the criminal, due process model created unnecessary barriers to the provision of treatment for seriously mentally ill persons. Although they acknowledged the necessity and benefit of the legal reforms of the 1960s and 1970s, they argued that the legal hurdles erected by restrictive state commitment statutes operated to deprive many seriously ill persons of mental health care and related social services that could substantially improve their lives.[4] Pressure soon mounted for adoption of laws that would return more power and discretion to mental heath

professionals in the commitment process. Several state legislatures amended their commitment laws to broaden the legal grounds for commitment. For example, in 1979, only six years after the enactment of stringent civil commitment criteria based on dangerousness, Washington State revised its civil commitment law to make it easier to hospitalize persons who were in need of care but not imminently dangerous to themselves.[5] Although this expansion of the legal authority to confine and treat mentally ill persons for therapeutic purposes had the expected result of significantly increasing the number of persons involuntarily committed, it had a number of troubling, unanticipated results -- for example, the *de facto* elimination of treatment and care provided by the public mental health system on a voluntary basis.[6] Scarce resources were simply shifted from voluntary services to involuntary care and treatment. That is, the expansion of Washington State's commitment authority was not coordinated with greater availability of resources to the mental health system. Unanticipated results such as these called into question the preoccupation with periodic calibrations of statutory commitment criteria as an effective way to deal with the problem of providing effective mental health care to those who need it.

The debate over the proper balance between stringent substantive and procedural protections applied to involuntary civil commitment, on the one hand, and broad legal authorization and power given to mental health professionals to confine and treat mentally ill persons, on the other, will undoubtedly continue unabated as long as reforms are viewed as efforts to advance narrow disciplinary concerns. Based on the presumption that substantive statutory criteria defining who is and who is not a proper subject for commitment actually make a difference in practice, tremendous energy has been expended in argument about the appropriate wording of the legal "test" for commitment. Although some commentators attempt to portray proponents of the competing models in positive terms,[7] all too often they are characterized in polar terms of good and evil accompanied by a "dismaying debate which has been marred by charges and countercharges that are overblown and unfair."[8] The debate has pitted doctors against lawyers and has galvanized support for either a "medical" or a "legal" model for statutory reform of involuntary civil commitment.[9]

The *Guidelines for Involuntary Civil Commitment* (hereinafter, *Guidelines*) are founded on five premises. First and foremost, it is presumed that the tendencies to view the complexities of the involuntary civil commitment process in abstract, polar terms -- e.g., doctors versus lawyers, the legal model versus the medical model, police power of the state versus the *parens patriae* function of the state, or personal liberties versus treatment needs -- are counterproductive.[10] Perhaps theoretically and historically useful, such dichotomies do not fit the realities facing the public mental health system today: a dramatic decline in the number of patients residing in public hospitals; an increase in the number of chronically mentally ill persons, many of whom are uninsured and poor; a burgeoning homeless population; the "transinstitutionalization" of mentally ill patients from mental hospitals to nursing homes, temporary shelters, and jails with inadequate care; a critical shortage of adequate community-based mental health care and related social services; and escalating costs of all human services at a time of increased pressures to control public expenditures. Indeed, there are signs pointing to a virtual breakdown of the public mental health system.[11]

Added to this bleak picture, and perhaps because of it, are efforts to expand the reach of involuntary civil commitment to persons -- including outpatients,[12] homeless mentally ill persons,[13] and cocaine abusers[14] -- not presently committable under most statutes. Whether one views such developments as legitimate expansions or as subversions of the coercive apparatus of the civil commitment process, it is clear that more is being asked of the involuntary mental health care system at a time when its resources may already be stretched too far.

Defining the flaws in the involuntary civil commitment process in terms of doctrinal extremes simply misses the point.[15] It may also overwhelm our abilities to do anything about them.[16]

The *Guidelines* attempt to refocus attention on practical issues and to recast larger problems into smaller, less arousing problems. Rather than focus on the "law on the books," where most of the debate over civil commitment has centered, the *Guidelines* focus on the system of involuntary civil commitment, its organization and structural arrangements, and its everyday administration, *viz.*, the "law in practice."[17] The National Task Force agreed that much good can be accomplished through less controversial changes in practice that require no new laws. Most of the fifty guidelines in this volume suggest improvements that can be accommodated under existing state laws without the necessity of statutory reform. A theme reflected throughout the *Guidelines* is that narrow disciplinary concerns (e.g., whether the medical model or the legal model should govern involuntary mental health care) and broad theoretical questions (e.g., whether the preference for liberty should take precedence over the need for help) are secondary to a properly administered civil commitment process based on common sense.

Second, it is assumed that there is a need for and social value in involuntary civil commitment for some severely mentally ill persons who will be harmed, and in some cases will harm others, unless some individual or agency intervenes.[18] This is not to say that the process has always worked well and that it has not been the instrument of much wrong. However, because the involuntary civil commitment process exists and is likely to continue to exist, it should be performed well in order to ensure that mentally ill persons who need help get that help in the most humane, effective, and efficient way possible. The

Guidelines further assume that legal safeguards to reduce the error of improper commitment need not be incompatible with this end.

Third, unless circumstances indicate otherwise, family members should be viewed as partners in the treatment and care of persons subject to involuntary commitment. American Psychiatric Association President John Talbott, speaking on behalf of his profession and urging an alliance of psychiatrists and family members, recently noted, "Our concerns, our goals, and our futures are one, linked by our common dedication to our patients, their relatives."[19]

Fourth, it is better to cooperate than to confront. Cooperation among the various disciplines, groups, agencies, and components of mental health-justice systems, instead of litigious confrontation, should be the first strategy tried for improving involuntary civil commitment. It may be the only viable strategy.[20]

Finally, improvement of the involuntary civil commitment process is not just a professional concern. It is a matter of concern to the average citizen and is a part of the broad public debate about the most appropriate response to the needs of people with mental illness. Public understanding is far from complete, and more education is needed. The stigma on victims of mental illness persists, as does the type of common ignorance which equates schizophrenia with a "split personality." Such important issues as "deinstitutionalization" and "homelessness" often are debated in public forums in more heat and smoke than light.

Development of the Guidelines

One can better appreciate the guidelines in this volume by understanding their history and development. In January 1981, the National Center for State Courts, through its Institute on Mental Disability and the Law, began an ambitious project to study and improve involuntary civil commitment laws and practices throughout the country. Funding for the Involuntary Civil Commitment Project was provided by the John D. and Catherine T. MacArthur Foundation, the Aetna Life & Casualty Foundation, a consortium of community foundations,[21] and the National Center for State Courts.

The Involuntary Civil Commitment Project is divided into three phases. The purpose of the first phase was research and development. Staff reviewed the professional literature related to involuntary civil commitment, compared the commitment laws in twenty states, and undertook extensive field research in six metropolitan areas: Chicago, Columbus (Ohio), Los Angeles, Milwaukee, New York, and Winston-Salem (North Carolina). The field research consisted of observations of commitment hearings and other commitment procedures (e.g., mental health examinations) and hundreds of individual and group interviews of judges, attorneys, law enforcement officials, public and private social service agency personnel, university professors, elected officials, representatives of advocacy groups, and mental health professionals. Following analyses of the research results, project staff wrote monographs that described the involuntary civil commitment process and made practical recommendations for its improvement in each of the six metropolitan areas which served as research sites.[22] Each monograph contained an analysis of relevant state laws; a detailed description of the organization, structural arrangements, and local practices; and recommendations for improving the fairness, quality, and actual operation of the involuntary civil commitment process. Drafts of these monographs were reviewed by and discussed with local officials, professionals, and interested citizens. Following revisions based on reviewers' comments, the monographs were widely distributed. A few served as bases for significant improvements.[23]

The July 1982 publication of a seventh monograph,[24] a comprehensive guidebook that synthesized the results of the first phase of the project and formed the research basis for the *Guidelines*, marked the completion of the research and development phase of the Involuntary Civil Commitment Project. The results of an independent, but related, study of the application of the "least restrictive alternative" doctrine in involuntary civil commitment proceedings also contributed to the research base.[25]

Phase 2 of the Involuntary Civil Commitment Project, begun in late 1982, was an effort to refine the provisional guidelines into nationally recognized standards and to encourage limited implementation of the innovations developed in the first phase. With the support of the Aetna Life & Casualty Foundation, hundreds of the monographs containing the recommendations and provisional guidelines resulting from phase 1 were distributed to judicial personnel, attorneys, mental health professionals, legislators, and others concerned with involuntary civil commitment. To increase the dissemination of the information contained in these mongraphs, project staff adapted them for publication in various law reviews and professional journals.[26]

The most significant component of phase 2 was a "standards development" effort which began in February 1984 and ended with the publication of this guidebook. Fifteen mental health professionals, judges, attorneys, and individuals representing advocacy groups, all leaders in the field of mental health law, agreed to serve on an interdisciplinary panel, the National Task Force on Guidelines for Involuntary Civil Commitment, that would develop practical guidelines for the improvement of involuntary civil commitment. (Their names and affiliations are noted earlier in this volume.) Other professional and lay experts, invited as observers but actually serving in many instances as *de facto* National Task Force members, joined in the effort.

Using the research results of the first phase of the project as a springboard, the process of development of the guidelines unfolded over a period of two years. "Black letter" guidelines were written and rewritten through an iterative process involving: (a) presentation by project staff of "issue statements" based on the results of the first phase of the project; (b) lively discussion, debate, and formulations of tentative guidelines by the National Task Force during formal meetings that took place periodically over the course of two years; (c) writing and rewriting of guidelines, commentaries, and notes by project staff, who served as reporters for the National Task Force; (d) reviews by the National Task Force of various drafts of the *Guidelines* prepared by project staff; (e) refinements based on further discussion and debate; and (f) final revisions.

The process was aimed to arrive at a consensus that reflected agreement about the underlying premises (see above) of the *Guidelines*. As might be expected, strong divergence of opinion among members of the National Task Force emerged on some issues. In the end, the National Task Force endorsed the *Guidelines* as they appear in this volume, recognizing that individual differences may still exist among members and that not every member may be in full agreement with every guideline. The commentaries accompanying the guidelines seek to reflect this diversity.

Plans for phase 3 of the Involuntary Civil Commitment Project are under way at this writing. Efforts will be made to put the *Guidelines* into the hands of those willing and able to use them and to advance the innovations developed in the project's first two phases.

Overview of the Guidelines

This guidebook and its fifty individual, but related, guidelines are designed for all those involved in the policy, planning, and administration of involuntary civil commitment throughout the country, including judges, mental health professionals, attorneys, law enforcement officers, advocates, program administrators, legislators, and representatives of citizen groups. To the extent possible, the eight parts of the *Guidelines* are organized chronologically, according to the typical steps in the involuntary civil commitment process, from the commitment petition or first police contact through the formal judicial hearing to eventual release or continued commitment of an individual. To some extent, this chronological order is, of course, artificial. Sequences of events may vary from jurisdiction to jurisdiction and from case to case, and some issues are relevant throughout the commitment proceedings.

The *Guidelines* address the following topics:

- essential foundations of the involuntary civil commitment process;
- the organization and administration of prehearing screening;
- detention and custody of persons by law enforcement officers;
- mental health examination, treatment, and disposition before court hearings;
- legal representation;
- court hearings;
- judicial determinations and case dispositions;
- posthearing matters.

Each of these topics is dealt with in a separate part of the *Guidelines*, each with its own brief introduction.

The guidelines, accompanying commentaries, and notes are presented in a uniform fashion. Each guideline proposes specific actions, procedures, or structural arrangements. A preamble or brief statement of principle complements proposals for specific actions whenever this enhances the clarity of the guideline or renders the guideline more independent of supporting commentary and references. Commentary and references accompany each guideline. As noted earlier, divergences of opinion among members of the National Task Force are noted in the commentary.

Importantly, the *Guidelines* are meant to guide improvements of involuntary civil commitment that can be accommodated within existing statutory frameworks. They are not intended to be models for legislative reform, though some of the guidelines may be used as such in some states. This feature alone distinguishes the *Guidelines* from previous efforts to improve the involuntary civil commitment process.[27]

Finally, a few words about scope and limitations are warranted. First, the Guidelines relate only to the involuntary civil commitment of mentally ill adults. Generalizations to juveniles, prisoners, mentally retarded or developmentally disabled persons, substance abusers, or sexual offenders who are alleged to be mentally ill should be considered fortuitous and not intended. Second, although the commentaries and notes accompanying the guidelines are often extensive, they are intended only to be explanatory and illustrative. They are not meant to be authoritative law reviews or exhaustive reviews of relevant literature.[28] Third, some important issues germane to involuntary civil commitment are dealt with only in passing: civil competency, informed consent, confidentiality, the right to refuse treatment, the rights of patients within institutions, the conditions of confinement, and the liability of mental health professionals, to name just a few. These issues are not addressed in the *Guidelines* not because they were considered unimportant or irrelevant to involuntary civil commitment by the National Task Force, but simply because they have been dealt with extensively elsewhere.[29]

Notes

1. *See* E. Beis, *Mental Health and the Law* app. A, at 297 (1984); Schwitzgebel, *Survey of State Commitment Statutes*, in *Civil Commitment and Social Policy* 47, 53 (A. McGarry ed. West Supp. *1981); State Laws Governing Civil Commitment*, 3 Ment. Disab. L. Rep. 206 (1979). *See generally*, R. Reisner*, Law and the Mental Health System* 330 (1985). For an excellent, encyclopedic review of statutes and case law pertaining to involuntary civil commitment, see S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* (3d ed. 1985). This book contains numerous tables providing important source material for the text. The book is also an excellent reference for locating specific statutory provisions that relate to the many aspects of the law concerning the mentally disabled.

2. For a discussion of the functions and objectives of involuntary civil commitment, see A. Brooks, *Law, Psychiatry and the Mental Health System* 605 (1974).

3. *See* A. Stone, *Mental Health and Law: A System in Transition* 43-82 (1975); Roth, *Mental Health Commitment: The State of the Debate, 1980*, 31 Hosp. & Community Psychiatry 385 (1980); Appelbaum*, Civil Commitment: Is the Pendulum Changing Direction?* 33 Law & Psychiatry 703 (1982); Mills, *Civil Commitment of the Mentally Ill*, 484 Annals 28 (1986); Keilitz & Van Duizend, *Current Trends in Involuntary Civil Commitment*, 31 Rehab. Psychology 27 (1986).

4. *See, e.g*., Lamb & Mills, *Needed Changes in Law and Procedure for the Chronically Mentally Ill*, 37 Hosp. & Community Psychiatry 475 (1986); Treffert, *Dying With Their Rights On*, 130 Am. J. Psychiatry 1041 (1973); Stromberg & Stone, *A Model Statute on Civil Commitment of the Mentally Ill*, 20 Harv. J. on Legis. 275, 277 (1983); Zusman, *The Need for Intervention: The Reasons for State Control of the Mentally Disordered* in C. Warren, *The Court of Last Resort: Mental Illness and the Law 110* (1982) [hereinafter cited as C. Warren, *The Court of Last Resort*].

5. Wash. Rev. Code Ann. § 71.05.010 to 71.05.930 (1978 & Supp. 1986).

6. See Durham & La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 Yale L. & Pol'y. Rev. 395 (1985); Durham, *Implications of Need-for-Treatment Laws: A Study of Washington State's Involuntary Treatment Act*, 36 Hosp. & Comm. Psychiatry 975 (1985). *See also* Wexler, *The Structure of Civil Commitment: Patterns, Pressures, and Interactions in Mental Health Legislation*, 7 Law & Human Behavior 1, 4-6 (1983).

7. *See* Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, in C. Warren, *The Court of Last Resort, supra* note 4, at 69.

8. *Id*. at 70.

9. Under medical models, mental health professionals have broad discretion to evaluate and to provide involuntary treatment and care to persons deemed mentally ill who may be unwilling to undergo evaluation, treatment, or care voluntarily. Legal models apply significant substantive and procedural safeguards to the commitment process that limit the discretion and authority of mental health professionals in involuntary civil commitment. The model statute on civil commitment published by the Mental Health Law Project in 1977, *Suggested Statute on Civil Commitment*, 2 Ment. Disab. L. Rep. 127 (1977), is often cited as an example of a legal model of involuntary civil commitment and contrasted with the medical model represented by the American Psychiatric Association's *Guidelines for Legislation on the Psychiatric Hospitalization of Adults*, published in 1982. *See, e.g.*, Schmidt, *Critique of the American Psychiatric Association's Guidelines for State Legislation on Civil Commitment of the Mentally Ill*, 11 New Eng. J. on Crim. & Civ. Confinement 11, 16 & n. 24 (1985). *But cf.* Stromberg & Stone, *supra* note 4, at 279.

10. As was noted by a member of the National Task Force, what is often missing from such views is the fact that the majority of persons who are the subject of the debate are persons with serious, long-term mental illnesses, many of whom are poor and without basic care services or the normal social supports. There is a tendency among those whose primary dedication is to civil liberties to see involuntary civil commitment merely as an instance of deprivation of liberty and to ignore the therapeutic aspects of commitment. The practical reality is that the lack of adequate community resources and inadequate organization and coordination in the delivery of community mental health services to mentally disordered persons create a continued reliance on institutions as a primary locus of care for such persons. In searching for a balance between conflicting views, the National Task Force sought to relate guidelines to current realities, and not to abuses of the past that may be largely irrelevant today due to the massive changes that have taken place in the legal, mental health, and social systems over the past twenty years. Some members of the National Task Force expressed doubts whether current relevance is totally achieved by many of the guidelines. However, all members of the National Task Force believed the Guidelines to be a useful reference that should inspire significant improvement of involuntary civil commitment.

11. *See* R. Reisner, *supra* note 1, at 387.

12. Keilitz & Hall, *State Statutes Governing Involuntary Outpatient Civil Commitment*, 9 Ment. Disab. L. Rep. 378 (1985).

13. New York City Mayor Edward Koch recently authorized police to round up anyone who appeared to be mentally ill and refused shelter and to bring him or her to a hospital for observation when the outside temperature in the city dips below 32 degrees Fahrenheit. Given New York City's burgeoning homeless population, some consider this program necessary and inevitable. To do otherwise constitutes cruelty, they say. Others disagree. The New York Civil Liberties Union, for example, bitterly criticizing this program and comparing it to kidnapping, has mounted a "freeze patrol" that advises homeless persons of their right to resist this program. *Abandoned*, Newsweek, Jan. 6, 1986, at 14, 19. *See generally* H. Lamb, *The Homeless Mentally Ill* (1984); Langdon & Kass, *Homelessness in America: Looking for the Right to Shelter*, 19 Colum. J.L. & Soc. Probs. 305 (1985).

14. Lieber, *Coping with Cocaine*, Atl. Monthly, Jan. 1986, at 39, 47.

15. If the energy that has been devoted to arguing the extremes of the issue can be channelled into finding creative solutions that accommodate both sides of the debate, a partial swing of the pendulum to a more moderate position ought not be an impossible task. With luck, the process may have already begun.

Appelbaum, *supra* note 3, at 704. *But cf*. Lamb & Mills, *supra* note 4, at 479 (recommending that criteria for commitment should be altered).

16. In an article about how we define our social problems, Professor Karl Weick noted that the "massive scale on which social problems are conceived often precludes innovative action because the limits of bounded rationality are exceeded and arousal is raised to dysfunctionally high levels." Weick, *Small Wins: Redefining the Scale of Social Problems*, 39 Am. Psychologist 40, 40 (1984).

17. *See* Shah, *Local and Mental Health System Interactions: Major Developments and Research Needs*, Int'l J.L. & Psychiatry 219, 254 (1981).

18. *See* Zusman, *supra* note 4, at 111. ("No doubt that with good educational systems, strong community support networks, and tolerance and goodwill by all citizens, the number of such disordered persons [those subject to involuntary mental health care] can be reduced below what it has been in the past.")

19. Talbott, *Viewpoint*, Psychiatric News, June 1, 1984, at 2. *See generally* Hatfield, *The Family as Partners in the Treatment of Mental Illness*, 30 Hosp. & Community Psychiatry (1979); Craig, Hussey, Parsons, & Seamans, *A Family Group Program in a State Psychiatric Hospital*, 36 Hosp. & Community Psychiatry 1317 (1985); Williams, Williams, Sommer, & Sommer, *A Survey of the California Alliance for the Mentally Ill*, 37 Hosp. & Community Psychiatry 253 (1986); Dunham, *APA's Model Law: Protecting the Patient's Ultimate Interests*, 36 Hosp. & Community Psychiatry 973 (1985).

20. *See* Keilitz & Van Duizend *supra* note 3, at 28-30; Shah, *supra* note 17, at 257; Pashall & Eichler, *Rights Promotion in the '80s*, 6 Ment. & Phys. Disab. L. Rep. 116 (1982). *Cf.* Appelbaum, The

Rising Tide of Patients Rights Advocacy, 37 Hosp. & Community Psychiatry 9 (1986).

21. The New York Community Trust, the Columbus Foundation, the Winston-Salem Foundation, the Della Martin Foundation, the Chicago Community Trust, the Milwaukee Foundation, the Gardner Foundation, the Frieda Brunn Trust Fund of Milwaukee County, the Cudahy Fund, and the Stackner Family Foundation.

22. W. L. Fitch, B. McGraw, J. Hendryx, & T. Marvell, *Involuntary Civil Commitment in the First Judicial Department, New York City* (1982); W. L. Fitch, *Involuntary Civil Commitment in Winston-Salem* (1982); I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* (1983); I. Keilitz, W. L. Fitch, & B. McGraw, *Involuntary Civil Commitment in Los Angeles County* (1982); I. Keilitz, *Involuntary Civil Commitment in Columbus, Ohio* (1982); J. Zimmerman, *Involuntary Civil Commitment in Chicago* (1982).

23. The monograph describing the commitment process in Milwaukee, I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* (1983), was hailed by the editors of the *Milwaukee Journal* as "the most hopeful sign of potentially meaningful reform that Milwaukee has seen in years." *It's Not the Law That's Faulty*, The Milwaukee Journal, March 11, 1983, at 14, col. 1.

24. Institute on Mental Disability and the Law, *Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment* (1982).

25. Institute on Mental Disability and the Law, *A Model for the Application of the Least Restrictive Alternative Doctrine in Involuntary Civil Commitment: Final Report of the Least Restrictive Alternative Project* (1984); McGraw & Keilitz, *The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment*, 6 Whittier L. Rev. 35 (1984); Keilitz, Conn, & Giampetro, *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice,* 29 St. Louis U.L.J. 691 (1985).

26. Fitch, *Involuntary Civil Commitment of the Mentally Ill: Implementation of the Law in Winston-Salem, North Carolina*, 14 N.C. Cent. L. Rev. 406 (1984); Keilitz, Fitch, & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 Sw. L.J. 238 (1984); Keilitz & Roach, *A Study of Defense Counsel and Involuntary Civil Commitment in Columbus, Ohio*, 13 Cap. U.L. Rev. 175 (1983); McGraw, Fitch, Buckley, & Marvel, *Civil Commitment in New York City: An Analysis of Practice*, 5 Pace L. Rev. 259 (1985); Van Duizend & Zimmerman, *The Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, 33 De Paul L. Rev. 225 (1984); Zimmerman & Fitch, *Involuntary Civil Commitment: The Discerning Eye of the Law*, 5 St. Ct. J. 5 (Fall, 1981); Keilitz, McGraw, & Van Duizend, *Improving the Involuntary Civil Commitment Process*, 7 St. Ct. J. 15 (Fall, 1983); Van Duizend, McGraw, & Keilitz, *An Overview of State Involuntary Commitment Statutes*, 8 Ment. & Phys. Disab. L. Rep. 328 (1984).

27. *See, e.g.*, Public Health Service, *A Draft Act Governing Hospitalization of the Mentally Ill, in The Mentally Disabled and the Law* (S. Brakel & R. Rock, rev. ed. 1971); Mental Health Law Project, *Legal Issues in State Mental Health Care: Proposals for Change -- Civil Commitment*, Mental Disability L. Rep. 73 (1977).

28. For a comprehensive review of statutes and case law in the mentally disability field, *see* S. Brakel, J. Parry, & B. Wiener, *supra* note 1.

29. *See generally* S. Brakel, J. Parry, & B. Wiener, *supra* note 1.

PART A
ESSENTIAL FOUNDATIONS

As noted in the Introduction, most of the guidelines in this volume address, in rough chronological order, the issues that arise as a person who is the subject of involuntary civil commitment "moves" through the various stages of the commitment proceedings, beginning with the filing of a petition for commitment or emergency detention and ending with involuntary mental health care or release. The three guidelines in Part A do not fit neatly into this chronological order. They set forth requirements that may not be crucial to the fair and workable resolution of an individual commitment case, but are essential to the improvement of the equity, efficiency, and effectiveness of, and public satisfaction with, the commitment process as a whole.

The involuntary civil commitment process in most communities involves families, law enforcement agencies, hospitals, community mental health agencies, courts, rehabilitation programs, and social service agencies. Indirectly, citizen and professional groups, legislatures, and universities shape the process. Many systemic problems in the commitment process arise that affect one or more of these components of mental health-justice systems, yet few forums exist to resolve these problems, due in part to the fragmentation of the current mental health-justice system.[1] Guideline A1 calls for the creation of interdisciplinary community coordinating councils made up of representatives of the components of the mental health-justice system involved in involuntary civil commitment. It urges that meetings of the councils become the forum for discussions of informal, expedient resolutions to the many systemic problems that arise in the commitment process. Without such a forum, many problems may remain unresolved or become embroiled in protracted polemics and misguided legislative reforms.

Guideline A2 encourages the creation of a comprehensive continuum of mental health and related social services available to individuals who become subjects of involuntary civil commitment. The goals of involuntary civil commitment are premised upon the existence of such a continuum of services, ranging from comprehensive community-based care to intensive inpatient hospital services. To ensure that available mental health and related health and social services in the community are known to those responsible for administering involuntary civil commitment, Guideline A2 recommends the preparation and appropriate distribution of a comprehensive guide to those services.

Finally, to contribute to the understanding of the operation of involuntary civil commitment, as well as to improve the quality of the process, Guideline A3 urges that involuntary civil commitment be subjected to vigorous and ongoing research and program evaluation. To assure that knowledge and information about the functioning of involuntary civil commitment is accumulated to facilitate research and to avoid piecemeal research and evaluation efforts that are initiated only when prompted by dramatic public events, Guideline A3 urges local jurisdictions to collect and to maintain data on the functioning of the commitment process on a routine basis.

Notes

1. Contrary to popular beliefs, courts typically become involved in a commitment case only after many professionals in law enforcement agencies, community mental health centers, or social service agencies have made threshold decisions regarding a person's suitability for commitment. For example, a candidate for involuntary civil commitment may first come to the attention of police or a social service agency. Alternatively, a community mental health center, after a series of failures with outpatient treatment, may decide that one of its clients meets the necessary criteria for involuntary care. These professionals may effect a person's temporary detention in an inpatient facility after some type of screening, social investigation, and review of allegations, petitions, and other documents supporting the need for involuntary care before formal involvement by a court. At this point, an allegedly mentally disordered person may be presented yet to another mental health facility for prehearing examination. Law enforcement agencies, having performed their duties of apprehending, transporting, and temporarily detaining a candidate for involuntary commitment, retreat from the case. Similarly, as long as a person remains an inpatient of a hospital, community mental health centers and social service agencies are removed from the case. Seldom are professionals in these agencies drawn back into a case, except indirectly, by means of their written record, until the person is released from the hospital. As the case moves closer to a formal hearing, the hospital and the court become dominant. Of course, during the formal judicial hearing (see Part F), the court exerts its strongest influence over the case.

A1. Community Coordinating Council

The complex nature of the involuntary civil commitment process and the varied needs of persons who become subject to the process require the cooperation and coordination of the various components of the mental health and justice systems involved.

An interdisciplinary community coordinating council, composed of representatives of all components of the mental health-justice system involved in involuntary civil commitment, should be established in each community to address common problems in the commitment process and their possible solutions. The council should make every effort to encourage participation of all agencies and groups

involved in the commitment process, including professional agencies and nonprofessional organizations, such as patient, family, and volunteer groups, and to foster coordination and cooperation among the members of the council and their representative agencies and organizations.

Commentary

Meeting the needs of seriously mentally ill persons is increasingly a community concern. Guideline A1 recognizes that involuntary civil commitment proceedings involve a variety of agencies and groups in the community. A community council is envisioned as an informal mechanism whereby these agencies and groups can address issues that cannot be addressed solely from the perspective of a single individual, discipline, group, or component of the mental health-justice system in the community. Ideally, a council would be composed of representatives of the courts with jurisdiction over commitment cases, mental health hospitals, community mental health centers, legal services organizations, law enforcement agencies, screening agencies, advocacy groups, social services agencies, local government, self-help groups, and family support groups. Representatives should include judges, attorneys representing respondents, attorneys for the petitioners and the state, psychiatrists, patients, psychologists, psychiatric nurses, social workers, mental health administrators, court clerks and administrators, private citizens, advocates, and police officers. Participation by representatives of patients and families, as well as private citizens, is crucial. The development of alternative mental health care, sadly lacking in many communities, often depends on the vigorous involvement of private citizens as well as professional agencies and organizations.

The council would provide a unique forum for discussion of issues and concerns and cooperation in finding solutions in an informal atmosphere before the issues and concerns develop into intractable problems and formal disputes. There are strong trends in the mental health law field generally, and in the area of involuntary civil commitment specifically, toward this type of avoidance of formal procedure and cooperation in promoting improvements.[1]

Persons who are subject to commitment proceedings are shared clients. Initially, they are the responsibility of one component of the system (e.g., law enforcement or crisis intervention services) and then another (e.g., short-term mental health services and the courts) as they "move" through the commitment process. Also, they are shared clients inasmuch as they often do not match one of the "pure types" (e.g., a chronically mentally ill, mentally retarded, alcoholic, or developmentally disabled person) upon which most care programs were designed.[2]

Within the circle of responsibility of one component of the mental health-justice system, certain procedures may be effective and meaningful, but the same procedures may be onerous and meaningless in another component with different goals and operations. Unfortunately, in most places throughout the country, linkages, coordination, and cooperation among the various components of the mental health and justice systems involved in involuntary civil commitment are nonexistent.[3] Where they exist, however, even in their formative stages, they appear to be beneficial.

In Milwaukee, Los Angeles, Minneapolis, and Phoenix, informal bodies of individuals representing the various groups, agencies, and units of government involved in mental health-law interactions meet regularly to discuss problems and solutions, pending legislation, and new procedures in involuntary civil commitment and related processes.[4] Such groups as these increase informal social interactions that routinely solve the problems of social systems.[5] Consider the following example. From the perspective of hospital admission personnel, it may seem eminently reasonable to ask a law enforcement officer to remain in the admission unit with an agitated person whom the officer has taken into custody pursuant to emergency commitment statutes until that person has been examined and admitted. However, such a request may frustrate the officer and be contrary to law enforcement policies and procedures. Given limited resources, law enforcement agencies, in particular, may find it difficult to allow officers to attend to mentally disordered persons in this fashion for long stretches of time. This problem cries out for the kind of cooperation, compromise, and practical solution a community coordinating council could facilitate. Left unresolved, the problem may lead to a reluctance or even a refusal by law enforcement personnel to intervene in all emergency mental health cases unless an arrest can be made. This could result in a polarization of the police and the mental health community and a consequent struggle to solve the issue by litigation and legislative reform.

Meetings of the council could also provide an educational forum. For example, in a meeting of Los Angeles County's Justice/Mental Health Committee held in May 1985, a representative of the Los Angeles County Department of Mental Health reported findings of a study of involuntary outpatient commitment laws and practices in Arizona.[6] The report and the discussion that followed are likely to lead to more informed policies and practices, should California enact involuntary outpatient commitment laws similar to those of Arizona.[7]

The involvement of lay representatives permits the groups they represent to serve as community educators. Often such groups are well positioned to respond to community fears about alternative treatment for people with mental illnesses. Lay representatives may also encourage the council to acknowledge and deal with legitimate fears about such issues as the dangerousness of mentally ill persons, declining property values, and agency responsiveness.

Because of the potentially important role that a community coordinating council can play in improving the involuntary civil commitment process, it is important that structure and staff resources be provided to the council. In some jurisdictions, a council may be established as an adjunct to local government units, commissions, or advisory boards. Several members of the National Task Force recommended that the commitment court in a local jurisdiction either take the initiative for establishing a community coordinating council or, alternatively, request that another component of the mental health-justice system, such as a community mental health center, accept the responsibility. Costs could be shared by the agencies most directly involved.

Notes

1. *See* Keilitz & Van Duizend, *Current Trends in the Involuntary Civil Commitment of Mentally Disabled Persons*, 31 Rehab. Psychology 27 (1985); *see also* Appelbaum, *Civil Commitment: Is the Pendulum Changing Direction*, 33 Law & Psychiatry 703 (1982); Paschall & Eichler, *Rights Promotion in the '80's*, 9 Ment. Disab. L. Rep. 441 (1982); Shah, *Legal and Mental Health System Interactions: Major Developments and Research Needs*, 4 Int'l J.L. & Psychiatry 219 (1981). For example, expressing the hope that psychiatrists are beginning to see families as allies, John Talbott, the former president of the American Psychiatric Association, recently noted:

> [Families] are seeking better relations with psychiatry and psychiatrists for example, by inviting them to speak at their meetings, participating in psychiatric committees, and writing for psychiatric publications. . . . [P]sychiatrists engaged in lobbying for public monies for the mentally ill have become aware that going it alone before congressional or state legislative committees to argue for more funding, appears singularly self-serving. . . . [T]hey see the necessity of coalitions, not only with the traditional mental health organizations, but with family groups . . . . Our concerns, our goals, and our futures are one, linked by our common dedication to our patients, their relatives.

Talbott, *Viewpoint*, Psychiatric News, June 1, 1984. *See also* Zinman, Taking Issue: Self Help: The Wave of the Future, 37 Hosp. & Community Psychiatry 213 (1986).

2. *See* Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 Am. Psychologist 794, 800 (1984).

3. Historically, for example, "police have little knowledge of, and liaision with social or even medical agencies, and seem to feel that those agencies' activities are irrelevant to the problems they themselves face." Cumming, Cumming, & Edell, *Policeman as Philosopher, Guide, and Friend*, 12 Soc. Probs. 276, 285 (1965). There is today a growing recognition that law enforcement officials and mental health personnel must work together to solve common problems. *See, e.g.*, American Bar Association, *Standards for Criminal Justice*, 7-2.2 (2d ed. 1980) (providing for development of joint policy on handling the admission of allegedly mentally disordered individuals for mental health evaluation).

4. *See* I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* iv, 115-18 (1983) (discussing Milwaukee County's Task Force on Human Services and the Law); Keilitz, Fitch, & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 Sw. U.L. Rev. 238, 259 (1984) (noting that the Justice/Mental Health Committee of Los Angeles County, sponsored by the Program Services Bureau of the Los Angeles County Mental Health Department, provides a forum for developing familiarity with community portals and gatekeepers to the commitment process in Los Angeles); Arthur, *The New Civil Commitment Process in Hennepin County*, 53 The Hennepin Law. 8, 9 (1983) (noting the creation in Minneapolis of a forum of professionals, including county attorneys, defense counsel, psychiatrists, psychologists, prepetition screeners, hospital administrators, social workers, and court personnel, to "engage in vigorous and useful discussions aimed at improvement" of involuntary civil commitment); *Mental Health Services Committee*, Ariz. Bar J. 34 (April/May 1985) (reporting that the Mental Health Services Committee -- a multidisciplinary panel of lawyers, associated professionals and psychiatrists interested in mental health law -- provides an opportunity for members of various professional groups to work together to achieve common goals).

5. *See generally*, C. Lindblom & D. Cohen, *Usable Knowledge: Social Science and Social Problem Solving* (1979); Shadish, *Policy Research: Lessons from the Implementation of Deinstitutionalization*, 39 Am. Psychologist 725, 727-28 (1984).

6. Minutes of the Los Angeles County Justice Mental Health Committee, May 7, 1985 (available from the Los Angeles County Department of Mental Health); *see also* Keilitz, Fitch, & McGraw, *supra* note 4.

7. Ariz. Rev. Stat. Ann. § 36-540.01 (Supp. 1985). *See* Guideline G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment."

A2. Continuum of Services: Directory

The existence of a continuum of care provided by state hospitals, community mental health services, and related social services is a prerequisite to fair and workable commitment practices. As mentally ill patients have increasingly moved in and out of hospitals over the last twenty-five years, the continuity of care provided to them has become a major consideration in the design of the mental health system.

(a) All jurisdictions should provide an integrated continuum of mental health and related health and social services available to respondents. The range of this continuum should encompass a broad array of coordinated community services as well as inpatient hospital services.

(b) An appropriate agency or group, under the direction of a community coordinating council or similar body (see Guideline A1), should prepare and regularly update a comprehensive guide to local mental health and related social services available to respondents. The guide should be made available for use to all individuals and organizational units of the mental health-justice system involved in the involuntary commitment process. The guide should include, but not be limited to, the following information:

(i) a complete listing of public, private, nonprofit, and voluntary mental health and social service resources (including advocacy agencies, self-help groups, and legal services organizations) and their locations serving mentally disordered persons;

(ii) admission or acceptance criteria, if applicable;

(iii) a short description of the types of treatment and services offered by each of the

resources listed and the service capacity of each resource, including its staff and size (e.g., bed capacity), organizational structure (e.g., outpatient aftercare service of a state hospital) and the financial arrangements necessary for services; and

(iv) a brief summary of the resource's history in providing services to involuntary patients.

Commentary

Many states require a continuum of mental health services as a matter of law.[1] Unfortunately, theory departs from actual practices; legislating policies and implementing them are separate processes that cannot be viewed as one and the same.[2] The mental health-justice system has yet to develop a spectrum of services to match the spectrum of needs of persons presented to it.[3] Guideline A2 urges not just detailed planning and statutory expression of a comprehensive system of care, but also the affirmative implementation of a full range of services.

A useful function of an interdisciplinary community coordinating council (see Guideline A1) may be to encourage and monitor the provision of the full range of needed services along the continuum. For example, a judge who ordered the release of a respondent after strict application of the statutory criteria for commitment and thoughtful consideration of all dispositional alternatives (see Guidelines G1 and G2), knowing that the respondent was released unprepared into a community, might bring the case to the attention of the council and press for the creation of adequate aftercare programs. In this way, the community coordinating council could help to ameliorate the problems of respondents "falling through the cracks" by exerting public pressure aimed at the integration of hospital and community mental health services and the creation of a continuum of services.

The nature of commitment proceedings may invite disciplinary parochialism that limits the knowledge of and, consequently, the respondent's access to a full continuum of available mental health treatment and services. Hospital psychiatrists, for example, may know little about outpatient mental health services available in the community. There is evidence that many chronically ill persons eschew outpatient mental health care, even when it is available free of charge, in favor of traditional hospital-based care, and many receive no care at all.[4]

The development and preparation of a guide to services potentially available to respondents is an important practical step toward a coordinated, comprehensive mental health system. Paragraph (b) recommends such a guide. The development of the guide may help to identify gaps in the continuum of services as well as facilitate use of existing services. If legislative mandates and policies for the provision of quality mental health treatment and services in the least restrictive setting are to have any practical meaning on a case-by-case basis, court officials, attorneys, mental health personnel, social service personnel, law enforcement officers, and others involved in the involuntary civil commitment process must have access to current information about available facilities and resources. The proposed guide should be updated regularly by a local mental health association or agency that has regular access to the services available to respondents.[5] Ideally, the information contained in the guide should be based upon observation and direct experience with the services listed, and not solely upon written descriptions or reports provided by the service providers. To prevent the guide from becoming too quickly outdated, its format should be such that the information contained in the guide can be expeditiously updated and communicated to all agencies, groups, and individuals responsible for administering the involuntary civil commitment process in a particular jurisdiction.

Notes

1. For example, California has provided for the establishment and operation of a continuum of alternatives to institutional care. *See* Cal. Welf. & Inst. Code §§ 5450, 5458 (West 1984 & Supp. 1986). A community residential treatment system must be developed in a such a way that patients "may move within the continuum to the most appropriate, least restrictive level of service." *Id.* § 5459 (West 1984). Residential alternatives that must be included in a system are short-term crisis alternatives, long-term programs, transitional services, structured living arrangements, rehabilitation programs, day treatment programs, socialization centers, in-home programs, and volunteer-based companion programs. *Id.* § 5458(a)-(h) (West Supp. 1986). The Los Angeles County Department of Mental Health's primary goal for the 1980s reflects the legislature's purpose of providing a spectrum of care. That goal is "to establish a comprehensive and coordinated single system of care with a full range of services in each region at multiple locations, available and accessible to all the residents of the County, primarily focusing on the severely and chronically mentally disordered population." J. R. Elpers, *Los Angeles County Department of Mental Health Goals and Objectives — Priorities for the '80's* 1 (1981). Arizona's Mental Health Services Act charges the director of Arizona's Department of Health Services to establish a statewide plan for community residential treatment for chronically mentally ill persons. The plan would provide a wide range of services in the least restrictive setting as alternatives to institutionalization. Four types of programs are to be included in the community residential treatment system: (1) a short-term crisis residential program as an "alternative to hospitalization for persons in an acute episode or situational crises requiring temporary removal from the home from one to fourteen days"; (2) a semisupervised, structured group living program; (3) a "socialization" or day care program; and (4) a residential treatment program that provides a "full day treatment program for persons who may require intensive support for the maximum of two years." (Ariz. Rev. Stat. Ann. § 36-550.05(B) (Supp. 1985). Chronically mentally ill persons are eligible for services in these programs regardless of whether they voluntarily seek the services or a court-appointed guardian requests, the superintendent of the Arizona State Hospital recommends, or a court orders that they receive the services. *Id.* § 36-550.06. *See generally* McGraw & Keilitz, *The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment*, 6 Whittier L. Rev. 35, 43-46 (1984).

2. Although the California and Arizona statutes provide for comprehensive mental health treatment and services systems, see supra note 1, such systems have not yet been developed. A state court recently ruled that state and local officials violated Arizona law by failing to provide a continuum of services to chronically mentally ill persons.

In *Arnold v. Sarn*, No. C-432355 (Ariz. Super. Ct., Maricopa County, Jan. 16, 1985) (preliminary ruling) *noted in Three Deinstitutionalization Cases in Progress*, 9 Mental & Physical Disability L. Rep. 120 (1985), the court ruled that the state legislature had charged the defendants, the Arizona Department of Health Services, the superintendent of the Arizona State Hospital, and the Maricopa County Board of Supervisors with providing an integrated system of care for the chonically mentally ill. The court found that the defendants had failed to carry out this responsibility. However, a Los Angeles County superior court recently refused to order that community-based programs be developed for residents of California institutions. The court stated that a state is not required to provide mental health services to its citizens. When it chooses to do so, it has considerable latitude in determining the nature and scope of its responsibilities. *Mental Health Association v. Deukmejian*, No. CA 000 540, slip op. (Los Angeles County Superior Court, April 12, 1985), *noted in Least Restrictive Services in California*, 9 Mental & Physical Disability L. Rep. 199 (1985); *California Rejects Right to Least Restrictive Treatment*, 3 Ment. Health L. Rep. 3 (May 1985); *In re Wicks*, 364 N.W.2d 844 (Minn. App. 1985) (reviewing treatment is an administrative, not a judicial, function, and there is no statutory authority to order the creation of new community-based services). *See generally* Okin & Dolnick, *Beyond State Hospital Unitization: The Development of an Integrated Mental Health Management System*, 36 Hosp. & Community Psychiatry 1201 (1985); Alrich, *Deinstitutionalization*, 62 Newsletter (U. Va., Institute of Government), September 1985; Shah, *Legal and Mental Health System Interactions: Major Developments and Research Needs*, 4 Int'l J.L. & Psychiatry 219, 255 (1981).

3. *Cf.* Petersilia, Turner, Kahan, & Peterson, *Executive Summary of Rand's Study, "Granting Felons Probation: Public Risks and Alternatives*," 31 Crime & Delinq. 379, 385 (1985) (concluding that the criminal justice system has not developed a spectrum of services to match the spectrum of criminality).

4. *See* Ware, Manning, Duan, Wells, & Newhouse, *Health Status and the Use of Outpatient Mental Health Services*, 39 Am. Psychologist 1090 (1984); *see also* Manning, Wells, Duan, Newhouse, & Ware, *Cost Sharing and the Use of Ambulatory Mental Health Services*, 39 Am. Psychologist 1077 (1984).

5. The development of such a guide to comprehensive services has been recommended for Milwaukee County. *See* I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 78-80 (1983). This recommendation has been adopted. "The goal was to include in a single volume all of Milwaukee's mental health resources. As a result of this recommendation, such a guide is now available and, as recommended, is supplemented by a computerized information system that augments and updates the data." *See Milwaukee Uses Institute's Recommendations to Reform Civil Commitment*, 11 National Center for State Courts Report 1 (August 1984).

A3. Research and Program Evaluation

The accumulation of information and knowledge about the functioning and consequences of the involuntary civil commitment process is impeded by the complex nature of the process and the fragmentation of the components of the mental health-justice system responsible for its administration. To the extent that the results of careful research and evaluation of the commitment process are made available for public knowledge and discussion, needed improvement of the process could be facilitated.

(a) Research and evaluation of the functioning and outcome of involuntary civil commitment, including careful descriptions of the various agencies and organizations and of the practices involved in the process, should be encouraged and supported at the local, state, and national levels.

(b) In order to facilitate research and program evaluation, all of the components of the mental health-justice system responsible for administering the involuntary civil commitment process -- including law enforcement agencies, screening agencies, community mental health centers, courts, community services, and hospitals -- should collect and compile statistics on the functioning and results of the processes for which they are responsible. The compilation of such statistics should be considered a routine administrative function. Researchers and evaluators should be required to submit detailed protocols describing proposed inquiries for review by an institutional review board or similar body made up of representatives drawn from different academic disciplines, groups, and agencies with interests in involuntary civil commitment.

Commentary

The various components of the legal system, the mental health system, and the social welfare system responsible for the commitment process can contribute to meaningful reform and improvement of the process by mobilizing their capacities for generating new information and knowledge. The purpose of Guideline A3 is to open the involuntary civil commitment process to legitimate scrutiny and thereby provide an empirical basis for its improvement. Paragraph (a) recommends that the relevant components of these systems encourage and support legitimate research and program evaluation efforts to generate this information and knowledge.[1]

Although it may seem obvious enough that limited knowledge and understanding of involuntary civil commitment seriously inhibits efforts to increase the equity, effectiveness, and efficiency of, as well as public satisfaction with, the commitment process, much reform of the process is, unfortunately, based not on sound empirical research but rather on beliefs, untested theories, and unfounded assertions, *viz*., what is considered "good sense." Guideline A3 encourages the replacement of at least some of this dogma with data.

Paragraph (b) recommends that all relevant agencies and programs collect and maintain statistics on the functioning of the commitment process as a routine administrative function.[2] It is unlikely that local and state agencies will conduct the types of research and programs that could be usefully undertaken. Limited resources for conducting research and the pressures of day-to-day program administration and service delivery militate against it. The most that realistically can be expected is that the

agencies leave traces, in the form of empirical data, on their functioning sufficient for sound program administration. If this expectation were met, however, research efforts initiated by researchers outside the agencies — research that otherwise would be prohibitively costly — may go forward. One role of a community coordinating council (see Guideline A1) may be to encourage and to support research and systematic evaluation of the involuntary civil commitment process by university-based researchers, research organizations, research organizations commissioned by state or federal agencies, and other local groups with interests in involuntary civil commitment.

Research has produced significant social benefits, but it has also posed troubling ethical questions. The research and program evaluation contemplated by Guideline A3 are those intended to generate knowledge and to enhance the understanding and ultimate improvement of involuntary civil commitment. However, because the interests and motivations of researchers and the subjects of their research may not be in accord, and possibly might be in sharp conflict, special procedures and regulations must be developed to protect the interests of the individuals, programs, and agencies that are the subjects of the research.[3] Generally speaking, research efforts that protect legitimate privacy interests of individuals and agencies, that do not involve deception, and that are aimed at legitimate purposes should be strongly encouraged. Proposed research that lacks those requirements should be denied.

Notes

1. The terms "research" and "program evaluation" are not precisely defined in Guideline A3. At a general level, the terms refer to activities designed to test hypotheses and to permit conclusions and inferences to be drawn and thereby to develop or to contribute to generalizable knowledge about the involuntary civil commitment process. See generally Shah, *Legal and Mental Health System Interactions: Major Developments and Research Needs*, 4 Int'l J.L. & Psychiatry 219 (1981); R. Reisner, *Law and the Mental Health System* 192-201 (1985); J. Monahan & L. Walker, *Social Science in Law* (1985).

2. *See* Guideline B1, "Screening Agency," for recommended statistics to be compiled by a screening agency.

3. *See* National Commission for the Protection of Human Subjects of Biomedical and Behavorial Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Department of Health, Education, and Welfare, April 18, 1979). *See generally Experiments and Research with Human Beings: Values and Conflicts* 36-56 (Washington, D.C.: National Academy of Sciences, 1975); R. Reisner, *supra* note 1.

PART B
SCREENING: ORGANIZATION AND ADMINISTRATION

Part B provides guidance for structural arrangements, staffing, and assessment processes used to determine a person's initial "entry" into the various agencies and organizations constituting the voluntary and involuntary mental health care system in a community. The guidelines prescribe the creation of screening agencies that exist as points of entry, where initial assessments are made to determine a person's suitability for referral to one or more of a community's mental health and social services, including, but not limited to, involuntary treatment and care.

The greatest activity in involuntary civil commitment proceedings occurs not in the court hearing – inaccurately considered by many to be the centerpiece of involuntary civil commitment – but rather during events before any formal judicial involvement.[1] A person initially may become subject to involuntary civil commitment by one of several ways: by being apprehended by police; by being brought to a hospital by relatives or friends; by being converted from a voluntary patient to an involuntary patient when, after entering a mental health facility voluntarily, the person attempts to leave against the advice of the facility staff; or, finally, by being taken into custody as a result of a legal petition submitted to and validated by a court. In most jurisdictions, very little screening, early diversion of persons from involuntary mental health care, and placement in appropriate voluntary care occurs except when a formal petition has been filed with and reviewed by a court. For the most part, persons become involuntary patients by means of "emergency" commitments resulting from apprehension by police or by simply appearing on the doorstep of a mental health facility.

Screening exists by statute in some jurisdictions and without statutory authorization in others. In practice, it is often circumvented by emergency commitments. The National Task Force agreed that screening of a person before he or she is involuntarily detained is circumvented too frequently, and more often than can be justified by the need for emergency intervention, and that much good can be accomplished by prehearing screening mechanisms. For many persons, the early stages in the involuntary civil commitment process constitute the entire extent of their involvement in the process. Indeed, in many localities the great majority of persons entering the mental health-judicial system never see the inside of a courthouse, and many persons are screened and diverted to more suitable alternatives, many elect to enter mental health treatment and care programs voluntarily, and some are discharged shortly after arrival at a mental health facility.[2] A court usually enters a case only after professionals in law enforcement agencies, social service agencies, or community mental health centers have made important decisions regarding the commitment of a person.

A person's initial contact with police, crisis intervention personnel, emergency room personnel, or other mental health workers does not lead invariably to involuntary hospitalization.[3] Many persons are diverted to appropriate alternative treatment or care, and others are simply released after initial contact with the commitment process. For example, the policy of the New York City Police Department encourages police officers to negotiate with public or private mental health agencies to resolve emergency situations.[4] As part of these negotiations, police officers often seek the assistance of a respondent's family or friends. In Arizona, police officers do not take a person possibly meeting the emergency detention criteria into custody until they have consulted by telephone with staff of the facility likely to receive the person.[5] In Columbus, Ohio, a mental health review unit of the probate court works cooperatively with hospitals and local community mental health centers to funnel all persons through the community centers for screening.[6] In nearby Dayton, Ohio, a court employee located in a community mental health center screens all petitions for involuntary civil commitment, diverting many cases. Finally, in Los Angeles, mobile psychiatric emergency teams -- consisting of community mental health workers and police -- serve as gatekeepers to the mental health-judicial system.[7] To confirm that a person warrants emergency detention, a team communicates the person's circumstances and behavior to mental health officials. These procedures encourage diversion to more appropriate, less restrictive treatment alternatives for those persons in need of help but not necessarily requiring involuntary inpatient hospitalization.

There is an implicit assumption that mental health screening and evaluation before a person is involuntarily detained in a hospital is preferable to a review of allegations supporting commitment and screening only after he or she is admitted to a hospital.[8] Although some state statutes acknowledge the desirability of screening and diversion from involuntary commitment before involuntary detention, few prescribe the mechanisms by which such actions can be undertaken. Part B prescribes the mechanisms whereby candidates for involuntary civil commitment are screened and, if appropriate, diverted from the commitment system to other forms of treatment and care. It is important to note that the guidelines in

this part can be considered by jurisdictions without necessitating statutory reform. Even in the absence of explicit statutory provisions for screening of involuntary civil commitment cases before judicial review, most state statutes permit the organizational structure and procedures for the type of screening recommended in this part.

Screening should begin as early as possible in the involuntary civil commitment process in order to avoid unnecessary infringement of liberty, to ensure that persons are guided quickly and effectively toward the placement and treatment indicated by their presenting problems, and to minimize needless waste of limited resources. Initial processing decisions are based not merely on whether the legal criteria for involuntary civil commitment are met. The threshold question may be whether the person who is considered a candidate for involuntary civil commitment is indeed mentally disordered. If so, are there alternative forms of treatment and care, other than involuntary civil commitment? Even if the person is not considered to be mentally disordered, he or she may require social services of some type. Is mandatory hospitalization necessary? Will the person consider seeking mental health treatment voluntarily? Answers to these questions require intervention and decisions long before a candidate for involuntary civil commitment has a judicial hearing.

Such early intervention may entail no more than a mental health worker answering a telephone call from a distraught individual who is seeking help for a family member. Referral to a community mental health center or a family support group may divert a person who may otherwise become subject to formal involuntary civil commitment proceedings. These early interventions should be based on knowledge of the mental health services delivery system in the area and should take into account such factors as the range of treatment and services available, the criteria for admission to various facilities, the security of particular mental health facilities, and the conditions within facilities. Good initial processing decisions also require an understanding of the linkages between the agencies.

> Take, for example, the rather routine case of an elderly disoriented man who, because he was prone to wander, was thought to be an appropriate candidate for state hospital commitment and an inappropriate candidate for a nursing home in his community — until a person familiar with the local scene mentioned a particular nursing home that happened to have a fence around it and that, therefore, would be sufficiently secure for that patient.[9]

Seven guidelines prescribing the organization and administration of screening are contained in this part:

B1. Screening Agency

B2. Mental Health Screening Officer

B3. Screening of All Respondents

B4. Application for Screening

B5. Review of the Screening Application; Interview of Applicant

B6. Screening by a Mental Health Screening Officer

B7. Screening Report

The first two guidelines describe the structural arrangements for the organization and administration of screening and the qualifications of those who should administer it. Guideline B1 provides for the creation of a community-based screening agency with responsibility for screening persons at the initial stages of involuntary civil commitment. The screening agency becomes the primary point of entry for all respondents. Guideline B2 prescribes the designation of a qualified mental health specialist, a mental health screening officer, charged with responsibility for providing screening services. The remaining guidelines prescribe the specific procedures for screening, including the preparation and review of a screening application, the responsibilities and duties of a mental health screening officer, and the preparation of a screening report and its provision to the court.

Notes

1. *See* M. J. Churgin, Delivery of Mental Health Services: The Emergency Room Experience, paper presented at the Tenth World Congress of Law and Psychiatry (June 1984).

2. *See* Keilitz & Van Duizend, *Current Trends in the Involuntary Civil Commitment of Mentally Disabled Persons*, 31 Rehab. Psychology 27 (1984).

3. *Id.*

4. *See* McGraw, Fitch, Buckley, & Marvell, *Civil Commitment in New York City: An Analysis of Practice*, 5 Pace L. Rev. 259 (1985).

5. *See Institute on Mental Disability and the Law, A Model for the Application of the Least Restrictive Alternative Doctrine in Involuntary Civil Commitment: Final Report of the Least Restrictive Alternative Project* 314-19 (1984).

6. *See* Keilitz & Roach, *A Study of Defense Counsel and the Involuntary Civil Commitment System in Columbus, Ohio*, 13 Cap. U.L. Rev. 175, 182 n. 23 (1983).

7. *See* Keilitz, Fitch, & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 Sw. U.L. Rev. 238, 250-54 (1984).

8. > Regardless of a code's particular substantive standard of commitment, its success both in locating the most appropriate treatment and in protecting a patient's liberty may well depend on whether it includes a statutory mechanism for screening commitment petitions. Screening should be required and should be done early in the commitment process by an agency or person thoroughly familiar with community facilities and programs. In a large number of cases, only a screening process is likely to locate the best dispositional alternative for the individual.

Wexler, *APA's Model Law: A Commitment Code by and for Psychiatrists*, 36 Hosp. and Community Psychiatry 981, 981 (1985).

9. *Id.*

B1. Screening Agency

Decisions regarding less restrictive alternatives to involuntary civil commitment in general, and compulsory hospitalization in particular, should be made as early and as competently as possible. Early intervention, screening, and appropriate diversion from involuntary civil commitment to alternative forms of mental health care and social services are in the best interest of the person, the family, the justice and mental health systems, and society as a whole.

(a) Every locale should designate or establish an agency, program, or administrative unit charged with the responsibility for screening all candidates for involuntary civil commitment. The screening agency should be the single point of entry for all candidates for involuntary civil commitment and the referral point for all inquiries regarding the initiation of involuntary civil commitment. It should also serve as a source of information about civil commitment and all other alternative services available in the community. A screening agency should divert from commitment those who are not ill and also those who can be helped by other, less drastic measures.

(b) A screening agency should compile and maintain statistics regarding sources and the number of referrals and applications for involuntary civil commitment, the number and types of persons screened, the consequences of screenings (e.g., referrals to social services, diversion to voluntary hospitalization, or short-term hospitalization pending judicial hearing on commitment), and other information of use in assessing the characteristics of the population of persons subject to involuntary civil commitment and the quality of services provided to them.

Commentary

Guideline B1 encourages the designation or establishment, within each locale, of an organizational structure for receiving and screening all candidates for involuntary civil commitment. Such a screening agency should be the single point of referral and entry into the mental health-justice system for all those who become subject to involuntary civil commitment within the locale.[1] It should also serve as a clearinghouse of information about all voluntary and involuntary mental health and related social services available in the community. The number of screening agencies within a geographical area will depend on the size of the population served and the organizational structures of the mental health-justice system in that area. As a practical matter, the organizational and administrative structure in which a screening agency is placed will probably be decided by fiscal and political factors within a particular jurisdiction. Obviously, the makeup of a screening agency or unit will vary according to the population density of a jurisdiction. In rural jurisdictions, a screening agency or unit may consist of no more than one mental health worker devoting a portion of his or her time to screening. In urban areas where there is a high volume of involuntary civil commitment cases, several screening agencies may exist and each may employ several teams of mental health screening officers (see Guideline B2).

The purpose of screening agencies is to provide an organizational and administrative structure for equitable and uniform decisionmaking about mental health treatment and services in the least restrictive setting at the earliest possible point in involuntary civil commitment proceedings. Although initial contact with a screening agent may be an inquiry specific to involuntary commitment, the aim of the screening is to facilitate getting help for the individual referred, and not necessarily to help provide involuntary mental health services. That is, the aim is to find the most appropriate mental health treatment, care, or social services consistent with the individual's needs. Of course, it may be that any type of intervention would be inappropriate simply because the individual is functioning quite well in the community. In another case, it may be that a formal petition to a court followed by court-ordered mandatory treatment is the most appropriate action.

Screening agencies might be operated through the cooperation of state and local governments, by the private sector, or by some combination, with guidance provided by an interdisciplinary community coordinating council (see Guideline A1) or a similar body. In some jurisdictions, a screening agency may be an extension or adaptation of an existing facility that is accessible to and identifiable by the public (e.g., a community mental health center, a court clinic, or a special unit of a law enforcement agency). Staff of the screening agency or unit should have no ethical problem or conflict of interest in avoiding inpatient hospitalization in appropriate cases or, in other cases, in expediting involuntary, emergency treatment in a secure hospital setting.

Illustrations

At least several states -- Arizona, Minnesota, Ohio, and Washington, for example -- have created screening agencies. Other states, in order to improve the delivery of mental health services at the community level, have attempted to make community mental health centers the single conduit to treatment in hospitals.[2]

(a) Arizona

Arizona has provided in statute for screening agencies.[3] In nonemergency cases, an application for a court-ordered mental health evaluation of a respondent[4] is

filed with a screening agency.[5] Within forty-eight hours, the screening agency must complete a "pre-petition screening," including a review and investigation of the facts alleged in the application and, if possible, an interview with the respondent.[6] The great majority of persons who undergo prepetition screening are counseled and subsequently diverted from involuntary evaluation to less restrictive alternatives (e.g., voluntary inpatient or outpatient treatment or halfway house placement). If the screening agency determines that involuntary mental health evaluation of a person is warranted, however, it petitions the court to order the person to submit to a professional multidisciplinary evaluation.[7] Upon the advice of the screening agency,[8] the court may order the person to submit to a mental health evaluation at a designated time and place, on either an inpatient or an outpatient basis.[9]

Arizona prepetition screening is the review of each application requesting court-ordered evaluation, including "an investigation of facts alleged in such application, an interview with each applicant and an interview, if possible, with the proposed patient."[10] One purpose of the screening is to determine whether reasonable cause exists to believe the allegations in the application for court-ordered mental health evaluation. A second purpose is to attempt to persuade the person to undergo, on a voluntary basis, mental health evaluation or other mental health services less restrictive than involuntary inpatient hospitalization.[11]

In Tucson, three mental health care agencies function as screening agencies and perform prepetition screenings. Most are performed by the Southern Arizona Mental Health Center, a community-based facility that operates as a public, nonprofit agency within the Division of Behavioral Health Services of the Arizona Department of Health Services. Except in emergency cases, all applicants seeking the involuntary hospitalization of a person are referred to one of the three screening agencies. According to estimates provided by staff of the Southern Arizona Mental Health Center and corroborated by others, only one out of ten potential applications for involuntary evaluation results in the filing of a petition.[12] Ninety percent of the cases that come to the attention of the screening agency as candidates for involuntary civil commitment are diverted to voluntary inpatient or outpatient care, to placement in one of four halfway houses in Tucson, or to some other mental health or social service. In the cases in which the screening agency determines that the potential respondent does not require court-ordered evaluation, the application is not acted upon and the involuntary civil commitment proceedings terminate.[13]

It is important to note that although a mechanism for screening commitment petitions is presently part of the Arizona statutes, this was not always so. Even before a statutory mechanism for screening was in place, however, screening took place in Pima County, Arizona, as a practical matter because commitment petitions were made available only at the Southern Mental Health Center, a community-based mental health facility, rather than at the court. As a result of petitioners' contact with the community mental health center, staff informally screened petitions.[14] This illustrates the crucial point that local jurisdictions and states wishing to put screening structures and mechanisms into place can do so, even in the absence of statutory revisions.

(b) Minnesota

In Minnesota, a prospective petitioner must ask the county to conduct a preliminary investigation.[15] The request is made to a "designated agency" selected by the county board to provide services pursuant to civil commitment statutes. The designated agency must then appoint a "screening team" to conduct the investigation. Although the composition of the screening team is not specified in the Minnesota statute, one such team in Hennepin County is composed of one staff psychiatrist, one licensed consulting psychologist, four social workers, five drug counselors, three mental health workers, and four nurses.[16] In other jurisdictions, a "pre-petition screening team" consists of as few as two professionals. For example, in Duluth, when a referral to the screening agency concerns an individual who is not currently receiving social services, the team consists of two social workers in the St. Louis County Social Service Department.[17]

According to a brochure prepared by the Hennepin County Mental Health Division:

> The pre-petition screening program was established by Hennepin County to provide a thorough investigation into the appropriateness of proposed petitions for commitment for mental illness or inebriety, and to thoroughly explore less restrictive alternatives to involuntary civil commitment. The professional staff consists of psychiatrists, psychologists, psychiatric social workers, a clinical nurse specialist, chemical dependency counselors and mental health workers who will meet with prospective petitioners, family members and service providers, as well as with the proposed patient in his environment.[18]

Interestingly, before 1982, the Minnesota Hospitalization and Commitment Act made no formal provisions for any form of prepetition screening. Nevertheless, even then most of the counties in Minnesota had some form of prepetition screening. The Minnesota Supreme Court's Study Commission on the Mentally Disabled and the Courts reported that in 1979, ninety percent of the counties indicated some form of prepetition screening, ranging from as little as a county welfare worker supplying the county attorney's office with the substance of a petitioner's case to county workers interviewing ninety-nine percent of all proposed patients before a formal petition was drafted. Other types of procedures for prepetition screening noted in the Minnesota Supreme Court report included reviews of alternatives to commitment, multiple

conferences with the proposed petitioner, assistance provided to prospective petitioners in drafting petitions, and other investigatory procedures.[19] The Minnesota Supreme Court's Study Commission recommended that each county create a procedure for prepetition screening independent of the county attorney's office.[20]

(c) Ohio

A court in Ohio provides a number of checks and balances before it permits an official affidavit to be filed and the involuntary civil commitment process set in motion.[21] The court usually refers the affiant to a psychiatrist, to a psychologist, or, most commonly, to a "pre-screener" (a social worker) at one of the community mental health centers in Columbus. These mental health personnel investigate the allegations of the affiant by interviewing both the affiant and the respondent (if possible) and reviewing available records. This procedure screens and diverts the majority of cases to less restrictive treatment or protective services.[22] The screening is accomplished in coordination with the deputy clerk of the probate court, hospital officials, and law enforcement personnel. A person seeking judicial hospitalization of another contacts either the probate court or one of the hospitals and, in turn, is referred to the prescreener in the nearest community mental health center. A certificate or "doctor's letter" may be completed by a private psychiatrist or psychologist. When such is the case, no prescreening is performed by the community mental health centers. However, the prescreener may speak to the deputy clerk or the potential affiant in an attempt to determine whether his or her allegations warrant direct intervention by the community mental health center.

(d) Law Enforcement-Social Service Agency Agreement

The preceding examples illustrate screening agencies operated primarily through arrangements between local commitment courts and mental health agencies. Networks established by formal agreements between law enforcement agencies and human service provider organizations have also been created in some communities to handle mentally ill persons, homeless persons, and "public inebriates" and to accomplish a screening function.[23] For example, in Los Angeles, the police department signed a memorandum of agreement with several city and county agencies providing for mutual support in situations involving mentally ill persons.[24] The Los Angeles County Department of Mental Health agreed that it would evaluate and, when necessary, care for suspected mentally ill persons brought to one of its facilities by police officers. The Los Angeles Police Department agreed to establish a special detail staffed on a twenty-four-hour basis by officers whom all police officers would be instructed to call for help in cases of suspected mental illness. This special mental health evaluation detail screens cases on the telephone or at the scene. Disposition may range from simply transporting the person back to his or her home to making the appropriate arrangements for short-term, involuntary detention at a mental health facility. Officers in the special detail are able to use a twenty-four-hour "hotline" telephone number to confer directly with officials of the mental health department.

In Galveston County, Texas, the sheriff's department includes a unit of five law enforcement officers who respond to requests by any police officer in the county for on-site evaluation of persons who are suspected of being mentally ill. If the special mental health deputy determines that professional mental health evaluation is required, he or she takes responsibility for the person, allowing the police officer to return to normal duties.[25] If emergency mental health intervention is necessary, the mental health deputy may make immediate contact with emergency mental health personnel to inform them of an imminent emergency admission. The deputy may remain with the person in the mental health facility if the emergency evaluation is conducted on an involuntary basis.

In Birmingham, Alabama, the police department includes a team of "community services officers."[26] Members of this civilian team affiliated with the police department are professional social workers who are on call from 8 a.m. to 11 p.m., seven days a week, to assist and to relieve uniformed police officers in determining appropriate disposition for persons who are suspected of being mentally ill. A police officer may call a community services officer in cases that require police contacts with social service and mental health agencies.

Other types of arrangements between law enforcement agencies and human service agencies have been formed in various parts of the country.[27]

Data Collection

In order to provide a basis upon which screening, referral, diversion, and release decisions can be monitored and assessed, screening agencies should compile and maintain data regarding the flow of persons through the screening process and should regularly provide this information to the court, treatment and care facilities, social services, the state agency responsible for mental health and mental retardation programs, as well as community coordinating councils. The statistics compiled and maintained by the screening agency may include, but not be limited to, (1) the number of persons screened, (2) the sources of referrals to screening agencies, (3) the number of persons taken into custody, (4) the number of persons taken into custody who are released shortly after screening, (5) the number of persons who are not referred to treatment or care, (6) the number of persons who are referred for care and treatment to community-based facilities on a voluntary basis, (7) the number of persons admitted involuntarily, (8) the number of persons for whom a petition for involuntary civil commitment is prepared and filed, (9) the number of involuntarily admitted persons who convert to a voluntary status after

admission but before a judicial hearing, (10) the number of involuntarily admitted persons who are transferred to another facility before the judicial hearing, and (11) the number of involuntarily admitted persons who are released before a judicial hearing.

It is important to note that the statistics can be compiled and maintained without identifying individual patients. Revealing patients' names and other identifying data may violate principles of confidentiality and make patients less willing to undergo treatment and care on a voluntary basis.[28]

Notes

1. *See* Leon & Braisted, *Single-Point Entry: An Organizational Form in the Delivery of Services to the Aged*, 21 J. Applied Behav. Sci. 459 (1985).

2 *See, e.g.,* de Raismes*, A Critique of the Model State Law on Civil Commitment of the Mentally Ill*, 14 Colo. Law. 1206, 1214 (1985) (noting that Colorado's Division of Mental Health has cooperated with community-based agencies to establish community mental health centers as the single conduit to hospital treatment).

3. *See* Ariz. Rev. Stat. Ann. § 36-520 (Supp. 1985). Minnesota's mental health law makes similar provisions for a "pre-petition screening team." Minn. Stat. Ann. § 253B.07(1) (West Supp. 1985).

4. Ariz. Rev. Stat. Ann. § 36-520(A)-(C) (Supp. 1975-1984).

5. *Id*. § 36-501.28.

6. *Id*. § 36-521; *see also id*. § 36-501.23.

7. *Id*. § 36-521.D.

8. *Id*.§ 36-523.B.

9. *Id*. § 36-529.A.

10. *Id*. § 36-501.23.

11. *Id.; see also id*. § 36-521.

12. Institute on Mental Disability and the Law, National Center for State Courts, *A Model for the Application of the Least Restrictive Alternative Doctrine in Involuntary Civil Commitment: Final Report of the Least Restrictive Alternative Project* 291-323 (1984).

13. No more than one out of three respondents in Tucson comes into contact with the involuntary civil commitment system on an nonemergency basis. *Id*. at 317.

14. *See* D. Wexler, *Mental Health Law: Major Issues* 72-74 (1981).

15. Minn. Ann. Stat. § 253B.07(1) (West Supp. 1985). *See also* Janus & Wolfson, *The Minnesota Commitment Act of 1982: Summary and Analysis*, 6 Hamline L. Rev. 3, 25 (1983).

16. *See* Janus & Wolfson, *supra* note 15, at 25.

17. Erickson, *Minnesota Commitment Act – 1982: Pre-Petition Guidelines for Intake Social Workers, in Civil Commitment in Minnesota* 1, 14 (Advanced Legal Education, Hamline University School of Law, 1985).

18. Hennepin County Mental Health Division, *Pre-Petition Screening Program* (Brochure, no date).

19. Supreme Court Study Commission on the Mentally Disabled & the Courts, *Civil Commitment in Minnesota* 16-17 (July 1979).

20. *Id*. at 75.

21. *See* I. Keilitz, *Involuntary Civil Commitment in Columbus, Ohio* 24-26, 37-39 (1982); Keilitz & Roach, *A Study of Defense Counsel and the Involuntary Civil Commitment System in Columbus, Ohio*, 13 Cap. U.L. Rev. 175, 180-82 (1983). Although the prescreening mechanism is a positive aspect of the commitment process in the Columbus system, the authority by which it exists may have to be clarified by the court. The Ohio statute requires an investigation such as that provided by the prescreening procedure in Columbus, but only after receipt of the affidavit. Ohio Rev. Code Ann. § 5122.13 (Page 1981). Further, the statute provides that a mental health certificate may be required with an affidavit, though there does not seem to be a legislative intent to provide the certification under authority of the court. *Id*. § 5122.11.

A potential problem with the prescreening procedures in general, a problem that was raised by a local psychiatrist in Columbus, may stem from the fear of liability. In the absence of an affidavit invoking the jurisdiction of the court, proceeding to an individual's home and conducting a mental health examination constitutes an intrusion on that individual's privacy. In the absence of an affidavit or a court order authorizing the prescreening process, the process carries a high risk of liability.

22. The investigation, review, and examination of mental health cases conducted by "pre-screeners," one in each of the three community mental health centers in Columbus, seem to have evolved from two separate provisions in the Ohio statute.

> The affidavit may be accompanied, or the court may require that such affidavit be accompanied, by a certificate of a psychiatrist, or a certificate signed by a licensed clinical psychologist and a certificate signed by a licensed physician stating that he has examined the person and is of the opinion that he is a mentally ill person subject to hospitalization by court order, or shall be accompanied by a written statement by the applicant, under oath, that the person has refused to submit to an examination by a psychiatrist or by a licensed clinical psychologist and licensed physician.

Ohio Rev. Code Ann. § 5122.11 (Page 1981).

> Upon the receipt of the affidavit . . . the court may order an investigation.
>
> At the direction of the court, such investigation may be made by a social worker or other investigator appointed by the court. Such investigation shall cover the allegations of the affidavit and other information relating to whether or not the person named in the affidavit or statement is a mentally ill person subject to hospitalization by court order, and the availability of appropriate treatment alternatives.

Id. § 5122.13. The prehearing investigation performed by the community mental health centers in Columbus appears to be an adaptation of these two provisions in statute insofar as the screening report serves as the certificate supporting the affidavit before the affidavit is actually filed, instead of being limited to the investigation of the allegations of a completed affidavit authorized by § 5122.13.

23. Twelve such networks were recently studied by Abt Associates, Inc., under a contract with the National Institute of Justice, Department of Justice. The networks were led either by law enforcement agencies or by social service agencies, including the following: special uniformed units of law enforcement agencies in Erie, Pennsylvania, Galveston, Texas, and Los Angeles; special civilian units within law enforcement agencies in Birmingham, Alabama, and Rochester, New York; single social service facilities in Boston, Montgomery County, Pennsylvania, and San Diego; units within social service agencies in Fairfax County, Virginia, and Madison, Wisconsin; and multiple components of the social service systems in Washtenaw County, Michigan, and the New York City metropolitan area. Abt Associates, Law Enforcement/Social Service Agency Agreements (Draft Report, National Institute of Justice, Contract No. NIJ-J-LEAA-001-81) (April 1986).

24. *Id*.

25. *Id*.

26. *Id*.

27. *Id*.

28. The King County, Washington Superior Court, in *Peninsula Counseling Center v. Rahm*, docket No. 84-2-13001-9 (1985), held that Washington's "mental health client tracking system" violates the patient's right to privacy under the United States and Washington constitutions.

The two main purposes of this system are to get an unduplicated count of patients receiving state-subsidized treatment in order to determine the cost-effectiveness of the state's programs and to track chronically mentally ill individuals to ensure continuity of care. These purposes are accomplished by having mental health centers supply information, via computer terminals, to the state concerning patients who are acutely mentally ill, chronically mentally ill, or in a crisis situation. The information to be supplied includes the patient's name, birthdate, ethnic background, sex, diagnoses, symptoms, and treatment.

However, in *Peninsula Counseling Center* the court held that the required reporting of a patient's name and diagnoses intrudes into the confidential relationship between a patient and his therapist, thereby violating the right to privacy found in both the United States and the Washington constitutions. The court reasoned that while the state has a legitimate interest in its tracking system, the reporting of names and diagnoses intrudes much further than necessary to achieve these purposes, and, according to expert testimony, an effective system could be created without the actual use of names. The state is appealing the decision.

B2. Mental Health Screening Officer

Prehearing screening is a complex process that requires the participation of trained professionials.

(a) A mental health screening officer or team of officers should be assigned to each screening agency or unit to perform prehearing screening.

(b) Mental health screening officers should be

(i) experienced in the diagnosis, treatment, and care of mental disorders,

(ii) knowledgeable about the continuum of mental health treatment and services available to respondents in the community, and

(iii) knowledgeable about and experienced in applying the statutory, judicial, and administrative rules governing involuntary civil commitment.

Commentary

Guideline B2 provides for the positioning of a mental health or social services provider in each screening agency or unit and prescribes the minimal qualifications of mental health screening officers.[1] Only a few states have provided for professionals to conduct prehearing screening and evaluation of persons who are subject to involuntary civil commitment. The Missouri legislature has provided for "mental health coordinators," serving designated regions or facilities, to perform mental health screenings and evaluations and to investigate individuals referred to them as candidates for involuntary civil commitment.[2] Mental health coordinators must be mental health professionals (i.e., psychiatrists, residents in psychiatry, psychologists, psychiatric nurses, or psychiatric social workers) who have "knowledge of the laws relating to hospital admission and civil commitment."[3] The Minnesota Commitment Act of 1982[4] includes "formally designated members of a pre-petition screening unit" under its definition of a "health officer," who is empowered to take a person into custody pursuant to the Minnesota provisions for emergency "holds".[5] The act provides no guidelines as to the qualifications of members of a prepetition screening unit.[6] In practice, the professional staff of a prepetition screening team consists of psychiatrists, psychologists, psychiatric social workers, a clinical nurse specialist, chemical dependency counselors, and mental health workers who will meet with prospective petitioners, family members, and service providers, as well as with the proposed patient.[7] Although Arizona has extensive statutory provisions for prepetition screening,[8] no mention is made of the staff composition or qualifications of designated screening agencies. Possibly, the Arizona legislature meant to leave the staff composition and qualifications of screening agency staff to the Arizona Department of Health Services. Such intentions may be inferred from the nonspecific definition of a "screening agency" simply as "a health care agency licensed by the Department which provides those services required by such agency."[9]

Paragraph (b) outlines, in general terms, the qualifications of mental health screening officers. The precise education, training, and experience required of mental health screening officers are matters that best may be determined by individual jurisdictions, with guidance from the community coordinating council. Mental health and social services available in a particular geographic area may dictate that certain compromises be made in the qualifications of a mental health screening officer. For example, a rural jurisdiction with only a handful of mental health practitioners may need to secure the services of one of them on a part-time basis. The qualifications for a "mental health review officer" recommended in the Mental Health Law Project's model involuntary civil commitment statute[10] and those for court-appointed mental health evaluators in criminal proceedings recommended by the American Bar Association[11] may serve as good models.

Although National Task Force members agreed that mental health screening officers must possess the expertise necessary to perform competent screenings, they differed as to the relative weights that should be accorded formal professional education and degrees, specialized knowledge, and actual performance ability. Some argued that some minimal professional training and a professional degree should be a qualification criterion. Others expressed fears that requiring mental health screening officers to have advanced degrees in psychiatry, clinical psychology, or social work not only might preclude many individuals who would be able to perform adequate screenings from serving as mental health screening officers but also might make it prohibitively costly for some

communities to secure the services of mental health screening officers. This may be less of a problem in metropolitan areas, like Minneapolis,[12] where the combined qualifications of the members of a team would easily satisfy strict requirements. An acceptable substitute for formal professional training may be the requirement that mental health screening officers complete a training program developed to assure that they possess the requisite clinical and forensic knowledge to conduct competent screening. An appropriate model for such a program may be one developed by the Forensic Evaluation Training and Research Center of the University of Virginia for mental health professionals engaged in forensic mental health practice.[13] Most crucial, of course, is that mental health screening officers be thoroughly familiar with community facilities and programs. A mental health screening officer familiar with community services may be the only person likely to locate the best dispositional alternative for the respondent.[14]

Notes

1. The functions of a mental health screening officer, working at the threshold of involuntary civil commitment, are similar to those envisioned at the later stages in commitment proceedings for a "hospital case manager," "pre-placement coordinator," and "community placement case manager." See the consent decree in *Caswell v. Secretary of Health and Human Services*, No. 77-0488-CV-W-8 (W.D. Mo. Feb. 8, 1983).

2. Mo. Ann. Stat. § 632.300 (Vernon Supp. 1985).

3. Id. §§ 632.005(10), (12). *See also* Keilitz, Conn, & Giampetro, *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 St. Louis U.L.J. 690, 719 (1985).

4. Minn. Stat. Ann. §§ 253.B.01 to -.23 (West 1982 & Supp. 1985).

5. *Id*. § 253.B.02(9).

6. *See* Janus & Wolfson, *The Minnesota Commitment Act of 1982: Summary and Analysis*, 6 Hamline L. Rev. 3, 13 (1983).

7. *See* Hennepin County Mental Health Division, *Pre-Petition Screening Program* (Brochure, no date).

8. Ariz. Rev. Stat. Ann. §§ 36-501(23), -520, -521 (Supp. 1985).

9. *Id*. § 36-501(28).

10. A "mental health review officer" means a mental health professional, preferably independent of evaluation and treatment facilities, whose functions include the screening of petitions for evaluation and various preliminary determinations in the course of a commitment proceeding. *Suggested Statute on Civil Commitment*, 2 Mental Disability L. Rep. 132, 134 (1977). The duties of a mental health review officer are similar to those of the mental health screening officer proposed in Guideline B2. In all cases, the mental health review officer must accomplish a screening investigation to avoid unnecessary detention and evaluation when inadequate grounds exist to believe that the respondent presents a likelihood of serious harm to self or to others as a result of severe mental disorder. *Id*. at 136. This investigation must be completed before detention, unless the mental health review officer or a peace officer determines that immediate detention is necessary to prevent serious bodily harm to the respondent or to others. If the respondent is, as a result of such an emergency, detained before the completion of the screening investigation, the investigation must be completed within eighteen hours of the initiation of detention. *Id*. A "mental health review officer" is defined as follows:

> (a) a psychiatrist; (b) a psychologist with a doctoral degree from an accredited clinical program and such experience in the treatment and diagnosis of serious mental disorders as is required under rules and regulations adopted by the Commissioner; or (c) in counties in which sufficient persons having the qualifications required under the preceding subsections (a) and (b) are, with the approval of the Commissioner, found to be unavailable, a person with the following qualifications who has such experience in the treatment and diagnosis of serious mental disorder as is required under regulations adopted by the Commissioner: (i) an earned graduate degree in psychology from an accredited clinical program; (ii) a social worker with an earned graduate degree in social work with field training in a psychiatric facility from an accredited program; or (iii) a registered nurse with a graduate degree in psychiatric nursing from an accredited program.

Id. at 134.

11. American Bar Association, *Standards for Criminal Justice*, standard 7-3.10 (2d ed. 1980).

> The court must be satisfied that the professional's education, training and experience are sufficient to establish the clinical basis for the evaluation being conducted. Further, the professional must have acquired sufficient knowledge to enable him or her to perform the evaluation and to relate the opinion formulated as a result of the evaluation to the appropriate substantive law.

Id.

12. *See supra* notes 4-7 and accompanying text.

13. The University of Virginia Institute of Law, Psychiatry and Public Policy, *Annual Report of Forensic Evaluation & Research Center, Appendix* 6, A-17 (June 30, 1982).

14. *See* Wexler, APA's *Model Law: A Commitment Code by and for Psychiatrists*, 36 Hosp. and Community Psychiatry 981 (1985).

B3. Screening of All Respondents

A mental health screening officer should screen every candidate for involuntary civil commitment as early in the commitment process as practical.

Commentary

Assuming that a locale has established the required structural arrangements and staff in accordance with Guideline B1, "Screening Agency," and Guideline B2, "Mental Health Screening Officer," screening of candidates for involuntary civil commitment before short-term hospitalization should be the rule rather than the exception. Guideline B3 enunciates this general rule. As discussed below, exceptions to this rule may occur in emergency cases involving persons who require immediate attention by hospital staff. In such cases, however, screening has a role to play once the emergency abates.

The guideline does not reflect current practices in most locales, but it prescribes what may be a desirable and workable alternative to those practices. The underlying rationale is that decisions about appropriate case disposition should be made close to the point of entry into the justice-mental health system, at a time and place where

appropriate disposition can best be accomplished by qualified professionals well positioned to expedite the appropriate disposition. Guideline B3 requires that a mental health screening officer screen every respondent, regardless of whether commitment proceedings against a respondent have been or may be initiated on an "emergency"[1] or a "nonemergency"[2] basis as defined by statute. The emergency route to involuntary civil commitment is used most frequently, particularly in big cities.[3] Indeed, in some jurisdictions, statutorily defined emergency procedures may be used almost exclusively.[4] Obviously, if prehearing screening is prescribed only in nonemergency cases, screening is avoided in those jurisdictions. Because all respondents could benefit from screening, it should be available in all cases. Hence, the general screening procedures provided by Guidelines B4 through B7 apply to both emergency and nonemergency cases, however those cases may be defined in law and practice, although concerns for expediency and security in emergency cases may affect the timing of the screening.

Screening should occur as early as possible. For example, if a police officer is dispatched to investigate a report of disorderly conduct and ascertains that the subject may be mentally ill and dangerous, thereby being more appropriately handled by involuntary civil commitment than by criminal arrest, the officer at his or her first opportunity should confer with the mental health screening officer to determine whether to take the person to a psychiatric emergency room, a screening agency, or elsewhere. The mental health screening officer should then begin the screening process prescribed in Guidelines B4 through B7.

If a respondent is already in a mental hospital when involuntary commitment proceedings are initiated — for example, if an attending psychiatrist seeks to convert the respondent from voluntary to involuntary status — a hospital staff member responsible for the respondent should contact the mental health screening officer. Similarly, if a law enforcement officer has taken a respondent into custody and is unable, because of an emergency, to contact a mental health screening officer before the respondent is transported to an emergency unit of a hospital, a hospital staff member should contact the mental health screening officer as soon as possible after the emergency has abated. Hospitalization should not preclude investigation of the case by the mental health screening officer, screening in the hospital, and exploration of alternatives to commitment. Such continued screening and exploration of alternatives shortly after a respondent has been hospitalized on an emergency basis is provided in guidelines for "intake" social workers in Minnesota. In cases in which a respondent remains at liberty but is the subject of a petition for involuntary civil commitment, the investigation of the petition by court, mental health, or social service personnel should be merged with the screening process.

Notes

1. Emergency procedures generally apply when intensive mental health intervention is necessary immediately. They may include temporary involuntary detention before any formal hearing or adjudication and crisis intervention by mental health or law enforcement personnel. *See, e.g.*, Cal. Welf. & Inst. Code § 5150 (West 1984); Colo. Rev. Stat. § 27-10-105 (Supp. 1984); Mass. Gen. Laws. Ann. ch. 123, § 12 (West Supp. 1985); Minn. Stat. Ann. § 253B.05 (West 1982 & Supp. 1985); N.Y. Mental Hyg. Law § 9.39 (McKinney Supp. 1986); S.C. Code Ann. §§ 44-17-410 to -440 (Law. Co-op. 1985); Tex. Rev. Civ. Stat. Ann. art. 5547-26 to -30 (Vernon Supp. 1985); Wis. Stat. Ann. § 51.15 (West Supp. 1985).

2. Nonemergency procedures apply when immediate action is unnecessary. A court generally is involved following a petition by a third party alleging that a respondent is a proper subject for civil commitment. See, e.g., Cal. Welf. & Inst. Code § 5200 (West 1984); Colo. Rev. Stat. § 27-10-106 (1982); Mass. Gen. Laws Ann. ch. 123, § 7-8 (West Supp. 1985); Minn. Stat. Ann. § 253B.07 to .09 (West 1982 & Supp. 1985); N.Y. Mental Hyg. Law § 9.27 (McKinney 1978 & Supp. 1984-1985); S.C. Code Ann. § 44-17-510 to -580 (Law. Co-op. 1985); Tex. Rev. Civ. Stat. Ann. art. 5547-31 to -34 (Vernon Supp. 1985); Wis. Stat. Ann. § 51.20 (West Supp. 1985).

3. *See, e.g.*, Keilitz, Fitch, & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 Sw. U.L. Rev. 238, 247, 257-58 (1984); McGraw & Keilitz, *The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment*, 6 Whittier L. Rev. 35, 39 (1984); McGraw, Fitch, Buckley, & Marvell, *Civil Commitment in New York City: An Analysis of Practice*, 5 Pace L. Rev. 259 (1985). *See also* M. J. Churgin, *Delivery of Mental Health Services: The Emergency Room Experience*, paper presented at the Tenth World Congress of Law and Psychiatry (June 1984) ("In practice, in almost every jurisdiction, the emergency situation exception has swallowed the statutorily contemplated procedure with regard to involuntary commitment.").

4. *See, e.g.*, Keilitz, Conn, & Giampetro, *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 St. Louis U.L.J. 691 (1985). At least one court has recognized the risks involved in such unchecked procedures. *See In re Harris*, 98 Wash. 2d 276, __, 654 P.2d 109, 111 (1982) (en banc) ("The injurious effect of commitment can be manifested in a very short time.").

5. Erickson, *Minnesota Commitment Act — 1982: Pre-Petition Guidelines for Intake Social Workers, in Civil Commitment in Minnesota* 1, 7 (Advanced Legal Education, Hamline University School of Law, 1985).

> If hospitalization is required, ask the client to admit self to the hospital with your assistance. If the client refuses and is a threat to self or others, then contact the police or sheriff. Call the client's psychiatrist, if there is one, or arrange for any psychiatrist to reserve a bed in the hospital. If this cannot be accomplished, use the hospital emergency room as an admitting procedure. Then assist in arranging transportation, calling the ambulance if necessary, and notifying the Psychiatric Unit of the pending admission. Provide follow-up to the client and continue screening in the hospital to seek alternatives to commitment and to gather evidence for the petition. Cooperation with hospital social services is essential.

Id. at 8-9.

B4. Application for Screening

The first step in the screening process is the gathering of relevant information about the respondent. Persons seeking to initiate involuntary civil commitment of a respondent should complete a screening application containing the facts alleged to sup-

port commitment, including a description of overt acts or specific threats by the respondent and the behavior and events observed by the applicant indicating that the respondent may meet commitment criteria. The application should also include, if known to the applicant:

(a) a description of overt acts, specific threats (if any), or circumstances observed by persons other than the applicant indicating that the respondent meets commitment criteria;

(b) the respondent's present location, permanent residence, age, physical description, education, family history, history of mental and physical illness, previous treatment and hospitalization, and financial condition; and

(c) the names, addresses, and telephone numbers of family members and acquaintances of the respondent and of persons who may know facts supporting commitment.

Commentary

Guideline B4 provides for the beginning of the screening process, *viz*., the completion of an application for the screening of a potential case, referred to or received by a mental health screening agency, in which the applicant seeks the involuntary civil commitment of another person. Although a screening agency may accomplish *de facto* screening of cases on an informal basis by providing information about involuntary civil commitment and other services available in the community in response to general inquiries, an application for screening signals the start of a more formal process.

Guideline B4 requires that a standardized application be used to initiate screening whenever any person seeks the involuntary civil commitment of another. Ideally, the application should be completed before a mental health screening officer begins the screening process and before a respondent is involuntarily transported to a facility authorized to detain respondents or, alternatively, is diverted to some other, less restrictive mode of treatment or care. Circumstances frequently may dictate, however, that a mental health screening officer become involved in a case before an application is completed. For example, an applicant may be so emotionally confused and distraught that a mental health screening officer will have to assist him or her in completing the application. The guidelines developed by the St. Louis County (Minnesota) Social Services Department for social workers conducting "pre-petition screening" suggest that social workers build an alliance with the applicant or referral source in order to facilitate emergency mental health intervention with the respondent.[1]

In emergency cases, such as when a police officer has intervened after a threat of suicide, the application should be completed only after the respondent is detained and any potential danger is mitigated or abated. When a police officer, crisis intervention team, or mental health professional confronts a respondent who needs immediate intervention, a formal application for screening may have to follow an initial telephone consultation with a mental health screening officer in which the screening officer advises the caller to transport the respondent directly to a mental health facility in order to minimize the probability of violence. In such cases, the application is completed by one or more of the individuals involved in the case, including the mental health screening officer, shortly after the respondent has been involuntarily detained.

Another instance in which the completion of a formal application for screening is accomplished only after the respondent is already hospitalized is when a voluntary patient seeks discharge from a hospital against medical advice and his or her attending psychiatrist seeks to convert the patient to involuntary status. In such circumstances, the psychiatrist should inform a mental health screening officer of this action. The psychiatrist should then apply for screening, using the standard form.

Although the same basic procedure should be followed to initiate screening in both emergency and nonemergency cases,[2] when that procedure can begin may be dictated by the circumstances resulting from the respondent's condition. An applicant should, however, complete an application before formal screening continues as provided by Guidelines B5 through B7.

A mental health screening officer should not insist on a completed application at the expense of aggravating circumstances that require immediate intervention. The screening application is a tool to facilitate screening, not a roadblock to action. The application process should focus on the problem that the case presents. The mental health screening officer should exercise good judgment in balancing the need to gather information with the inconvenience to the applicant that the screening process may impose.[3]

An application should include, at a minimum, the applicant's statement of overt acts, specific threats, or circumstances observed by the applicant that led him or her to seek the respondent's involuntary civil commitment.[4] The remaining information should be supplied by the applicant if he or she knows it, but otherwise may be supplied later by the mental health screening officer.

Notes

1. Erickson, *Minnesota Commitment Act – 1980: Pre-Petition Guidelines for Intake Social Workers, in Civil Commitment in Minnesota 1, 7 (Advanced Legal Education, Hamline University School* of Law, 1985).

2. *See* Guideline B3, notes 1-2 and accompanying text.

3. A mental health coordinator in Kansas City, Missouri, noted that requiring applicants to travel to a mental health center in order to initiate commitment proceedings may cause hardships for some applicants who may have long distances to travel, may need to take time off from work in order to come to the office, and may have to

contend with parking and transportation problems. Keilitz, Conn, & Giampetro, *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 St. Louis U.L.J. 691, 724 (1985).

> One can argue that these practical difficulties facing applicants who pursue the involuntary detention of others are justified. The potential respondent's liberty interests justify a heavy burden placed on those seeking his or her involuntary detention. On the other hand, it can be argued that the relative inaccessibility of mental health coordinators for many applicants who may not be able to meet during daytime hours causes the more orderly non-emergency route to involuntary commitment to be closed, resulting in more cases being initiated on an emergency basis.

Id. at 724 n. 175.

4. *See, e.g.,* Erickson, *supra* note 1, at 6-7.

B5. Review of the Screening Application; Interview of Applicant

Before a mental health screening officer makes contact with a respondent, he or she should review the screening application and interview the applicant(s) to determine whether there is any basis for further intervention by the screening agency. The review of the screening application and the interview with the applicant should result in one of several general courses of action.

(a) If the mental health screening officer determines that no further intervention in the case is warranted, the application should be denied and the basis of the determination should be discussed with the applicant. If local law does not enable the mental health screening officer to veto or to override an applicant's desire to proceed with involuntary commitment, the officer should proceed with screening as provided in Guideline B6 if the applicant insists on proceeding. In such cases, however, the screening officer should communicate his or her reluctance to the applicant and explain to the applicant the basis for the reluctance.

(b) If the mental health screening officer determines, on the basis of the application and interview with the applicant, that the respondent needs mental health or social services short of commitment, the officer should immediately encourage and assist the applicant in obtaining the necessary and appropriate services for the respondent.

(c) If the mental health screening officer believes that there is a good basis for proceeding with commitment, he or she should conduct a full-scale screening as provided in Guideline B6.

Commentary

Guideline B5 recommends procedures to assure that a case referred to a screening agency does not proceed any further than necessary and that the most appropriate treatment and care is provided to the respondent as early as possible. Information and good advice, including encouragement and assistance provided to the applicant, are assumed to be reasonable preliminary steps before contact is made with the respondent. The application process and the personal interview with a screening officer may divert inappropriate commitment cases, just as potentially inappropriate commitment cases may be diverted from the commitment process when potential applicants are dissuaded from seeking involuntary treatment of a family member and encouraged to get help by other means after a brief telephone consultation with a screening agency.

The guideline provides for an expedient, fair disposition of a potential commitment case if, from a review of the screening application and an initial consultation with the applicant, a mental health screening officer can reliably determine that commitment proceedings are not warranted. Whenever a mental health screening officer determines that commitment of a respondent is inappropriate but believes that the referred person may benefit from some type of mental health or social services, he or she should encourage the applicant to pursue voluntary alternatives and assist the applicant in identifying facilities or programs suited to the respondent's needs.[1]

Guideline B5 provides that if the mental health screening officer determines that a basis for proceeding with the commitment case exists, he or she should proceed with screening as provided by Guideline B6. He or she should do the same, even where the review of the screening application and interview of the applicant establish no basis for proceeding with commitment if local law permits the applicant to insist in moving forward with the case for commitment. The mental health screening officer has an obligation, however, to communicate his or her misgivings about the merits of the case for commitment clearly and forthrightly to the applicant before proceeding with screening as provided by Guideline B6.2

Notes

1. The mental health screening officer may also assist the applicant in securing treatment or services for the respondent and, if possible and appropriate, encourage the respondent to accept them. If an applicant has not attempted to arrange treatment or services for a respondent on a voluntary basis, for example, a mental health screening officer might determine that involuntary proceedings should be postponed until voluntary alternatives prove ineffective. If, however, on the basis of the review of the screening application and the interview of the applicant, the screening officer determines that there is a probability of violence (e.g., due to a reported threat of suicide), the screening officer should expedite the application process and proceed to make contact with the referred person immediately. Of course, if there is a likelihood of personal risk to the screening officer, he or she should use the police or sheriff for assistance as needed. See Erickson, *Minnesota Commitment Act -- 1980: Pre-Petition Guidelines for Intake Social Workers*, in Civil Commitment in Minnesota (Advanced Legal Education, Hamline University School of Law, 1985).

> Determine the degree of personal risk involved in confronting the individual. If the situation is not safe, use the police or sheriff for assistance as

needed. Do not go to the client's home alone if there is a probability of violence. Also, if there is an imminent threat of suicide, the law enforcement people can act much more quickly and are empowered to pick up and detain an individual on a 72-hour hold at the hospital.

When personal risk has been minimized, contact and interview the referred person immediately.

Id. at 7.

2. *See, e.g*., Minn. Stat. Ann. § 253B.07(1)(c) to (e) (West Supp. 1985)

(c) When the pre-petition screening team recommends commitment, a written report shall be sent to the county attorney for the county in which the petition is to be filed.

(d) The pre-petition screening team shall refuse to support a petition if the investigation does not disclose sufficient evidence to support commitment. Notice of the pre-petition screening team's decision shall be provided to the prospective petitioner.

(e) If the interested party wishes to proceed with a petition contrary to the recommendation of the pre-petition screening team, application may be made directly to the county attorney, who may determine whether or not to proceed with the petition. Notice of the county attorney's determination shall be provided to the interested party.

Id. See also Ariz. Rev. Stat. Ann. § 36-521(C) (Supp. 1985); D.C. Code Ann. § 21-544 (1981) ("providing that the commission, after an informal hearing, shall order the release of the person and notify the court of that fact in writing"); Mo. Ann. Stat. § 632.300(3) (Vernon Supp. 1986) ("if the mental health coordinator determines that involuntary commitment is not appropriate, he or she should inform the person or his or her family or friends about those public and private agencies and courts which might be of assistance,"); Wash. Rev. Code Ann. §71.05.150(1)(a) (Supp. 1986).

B6. Screening by a Mental Health Screening Officer

A mental health screening officer should conduct an in-depth screening when a potential commitment case referred to a screening agency cannot be disposed of appropriately on the basis of the review of the screening application and consultation with the applicant, referral to voluntary services, or by some other means in accordance with Guidelines B4 and B5. Even though lesser measures — e.g., referral to voluntary services and consultation with the applicant — may have failed to resolve the problem, the purpose of in-depth screening is not simply to evaluate the need for commitment. Instead, the purpose of the screening is to assess the respondent's situation thoroughly, to verify the information provided by the applicant, and, if appropriate, to help the respondent choose and gain access to mental health care or related social services most appropriate to his or her needs.

In conducting the screening, a mental health screening officer should, at a minimum, attempt to interview the respondent, verify the information provided in the screening application, and gather as much information as is necessary to satisfy the purpose of the screening.

(a) The screening officer should interview the respondent personally at the screening agency, the respondent's home, or a treatment and care facility (if the respondent is already in the facility). If an interview cannot be conducted, the mental health screening officer should document, in writing, the reasons for not being able to conduct an interview with the respondent. The interview should include:

(i) an explanation of the nature, purpose, and possible consequences of the interview;

(ii) an assessment of the respondent's present mental and physical condition;

(iii) an assessment of the respondent's physical surroundings and social supports; and

(iv) an exploration of the respondent's suitability and willingness to undergo treatment and care appropriate to his or her needs.

(b) When screening is completed (it may or may not coincide with the interview of the respondent), if the mental health screening officer determines that commitment proceedings are inappropriate, the screening officer should encourage and help the applicant and the respondent to seek alternative modes of treatment and care or social services, if necessary, short of civil commitment of the respondent.

(c) If the applicant decides to pursue involuntary civil commitment of the respondent, despite recommendations to the contrary by the mental health screening officer, the screening officer should assist the applicant in taking the matter to the counsel for the state (see Guideline E3). After receipt and review of the screening report as provided in Guideline B7, the counsel for the state may or may not proceed with commitment proceedings. If warranted, the screening officer should be prepared to facilitate immediate medical or mental health intervention necessary to avoid serious bodily harm to the respondent or to others.

(d) If the mental health screening officer determines on the basis of the screening that commitment proceedings are appropriate, the screening officer should complete or assist the applicant in completing any documents or procedures necessary to initiate formal commitment proceedings and should submit a screening report to the appropriate mental health or judicial authority as provided by Guideline B7.

Commentary

The in-depth screening prescribed by Guideline B6 should be conducted in every case unless a case can be diverted from involuntary civil commitment proceedings on the basis of the screening application review and consultation with the applicant. Although the mental health screening officer should gather as much information as necessary, care should be taken not to cause the screening process to become an onerous and obligatory undertaking that adds yet another layer of bureaucracy upon an already formidable set of procedures leading to civil commitment. Information needs should be defined by the presenting problem. In some cases, it may be necessary to gather corroborating information from family members, friends of the respondent, and mental health and social service providers. In other cases, a single interview with the respondent may suffice to satisfy the requirements of screening.

The Minnesota commitment code provides for a preliminary investigation by a prescreening team. This preliminary investigation includes four elements similar to the requirements of Guideline B6.[1] First, the screening team must interview the respondent, if at all possible. If the interview cannot take place, reasons must be documented. Second, the prepetition screening team must interview other individuals with knowledge of the respondent and his or her circumstances. Third, the information provided by the petitioner (or applicant) must be verified. Finally, the team must identify and explore alternatives to involuntary civil commitment and give specific reasons for rejecting any of the alternatives. The prepetition screening team has an affirmative duty to refuse to support a petition if its preliminary investigation fails to indicate that commitment is proper.

The mental health screening officer's interview of the respondent should be done in person.[2] It should be conducted at the screening agency, although such factors as the respondent's condition and circumstances may dictate otherwise. The interview should begin with a fair explanation of the reasons why the mental health screening officer is contacting the respondent. Ideally, the respondent will already have been notified by the screening officer or the applicant regarding the appointment time, the location of the interview, and the involvement of others in the interview.

Although National Task Force members generally agreed that screening agencies or units, staffed by competent mental health professionals who are able to refer respondents to alternative programs, would be an improvement of involuntary mental health care, several members voiced concerns about the limited resources available to accomplish screening in most jurisdictions. They were concerned that strong advocacy for screening mechanisms would simply shift already severely strained resources from one area of need to another.[3]

Notes

1. Minn. Stat. Ann. §253B.07(1) (West Supp. 1985). *See also* Janus & Wolfson, *The Minnesota Commitment Act of 1982: Summary and Analysis*, 6 Hamline L. Rev. 3, 25 (1983).

2. *See* Erickson, *Minnesota Commitment Act — 1982: Pre-Petition Guidelines for Intake Social Workers, in Civil Commitment in Minnesota* 1, 11 (Advanced Legal Education, Hamline University School of Law, 1985).

> The involvement of others, such as relatives or friends, can provide support and information, but care must be taken not to make the group present at the screening interview so large it becomes threatening to the client.
>
> The first task in the interview is to introduce the team and to explain the purpose of it. Then determine the emotional state of the client . . . . Also determine if medical attention is required. Maintain control of the interview and explore all available treatment alternatives both out-patient and in-patient.

Id. at 10.

3. Similar concerns were recently expressed by Professor Alan Stone, chairman of the Council on Psychiatry and Law, which prepared the American Psychiatric Association's Model State Law of Civil Commitment of the Mentally Ill.

> Surely state screening systems staffed by appropriate mental health professionals who can refer these patients to alternative programs would be a valuable addition to mental health care. An explicit statutory provision . . . would therefore improve the model law. But such a provision is meaningful only when alternative programs actually exist and function effectively . . . . Psychiatrists for most of this century have recognized the value of screening and have been strong advocates of such screening; the difficulties have come in implementation.

Stone, *A Response to Comments on APA's Model Commitment Law*, 36 Hosp. & Community Psychiatry 984, 987 (1985).

B7. Screening Report

Whether mental health screening results in a refusal to support a formal petition for commitment, in expedited involuntary hospitalization, or in an intermediate resolution of the case, a mental health screening officer should prepare a written report of every case screened in order to preserve the factual basis for these and subsequent actions in individual cases. In addition to their value in individual cases, the reports also contribute to a database that may be used to evaluate and to improve the quality of services provided by the screening agency and other components of the mental health-justice system.

(a) A complete screening report should include:

(i) a copy of the screening application;

(ii) an account of the conduct and results of the screening, and;

(iii) a statement of the types of treatment and care that the mental health screening officer recommended, including a brief explanation of other reasonable alternatives that were considered but rejected.

(b) In all cases in which involuntary civil commitment is pursued, whether or not supported by the recommendations of the mental health screening officer, the screening report should be accompanied by copies of the commitment petition, the application for emergency detention, and other appropriate legal documents.

(c) In cases not proceeding toward civil commitment, contents of the screening report should not be divulged to individuals or agencies other than the screening agency, except for purposes of legitimate inquiries conducted in accordance with Guideline A3, "Research and Program Evaluation," or with the permission of the respondent and applicant and in accordance with existing laws and regulations governing confidentiality of patient records.

Commentary

In many jurisdictions, the information gathered through preliminary screenings and examinations is not utilized in subsequent commitment proceedings.[1] For example, in one jurisdiction a respondent undergoes four examinations before the probable cause hearing, but the results of only one report typically are filed with the court.[2] A cumulative base of factual information and expert opinions about a respondent is lost if a report for each preliminary screening or examination is not utilized.

Guideline B7 seeks to avoid this problem by encouraging use of the screening report in subsequent commitment proceedings and, if appropriate, as a basis of alternative treatment and social services provided to the respondent and his or her family. The report should be filed with the appropriate authority (e.g., the court or the attorney for the state) sufficiently in advance of the commitment decision to allow time for the decisionmaker to review it. As a general rule, in cases diverted from involuntary civil commitment, disclosure of the content of the screening report should be allowed only if such disclosure is in the best interest of the respondent. Also, the collection and storage of the screening report should be governed by and consistent with the purposes of screening. Obviously, allowing various individuals and groups unbridled access to the contents of the screening reports without the consent of the respondent poses a serious threat of breach of confidentiality and invasion of privacy. In some states, statutes impose certain requirements for disclosure of private data collected as part of prepetition screening[3] and commitment proceedings in general.[4]

Notes

1. *See, e.g.*, Keilitz, Fitch, & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 Sw. U.L. Rev. 238, 270-71 (1984).

2. I. Keilitz, *Involuntary Civil Commitment in Columbus, Ohio* 54-55 (1982).

3. See Minn. Stat. Ann. §§ 13.01-.88 (West Supp. 1985); Janus & Wolfson, The Minnesota Commitment Act of 1982: Summary and *Analysis*, 6 Hamline L. Rev. 3, 26 (1983).

4. *See, e.g.*, Alaska Stat. § 47.30.845 (1984); Ark. Stat. Ann. § 59-1416(14) (Supp. 1985); Cal. Welf. & Inst. Code § 5328 (West Supp. 1986); N.M. Stat. Ann. § 43-1-19 (1984); N.Y. Mental Hyg. Law § 33.13 to .14 (McKinney Supp. 1986); Ohio Rev. Code Ann. § 5122.31 (Page 1981); Pa. Stat. Ann. tit. 50, § 7111 (Purdon Supp. 1985); Tex. Rev. Civ. Stat. Ann. art. 5547-87 (Vernon Supp. 1986); Cf. 42 U.S.C. § 9501(1)(H)-(I) (1982); American Psychiatric Association, *Model Law on Confidentiality of Health and Social Service Records*, 136 Am. J. Psychiatry 136 (1979). *See generally* Appelbaum, *Confidentiality in Psychiatric Treatment*, in *Psychiatry* 325 (L. Grinspoon ed. 1982); T. Gutheil & P. Appelbaum, *Clinical Handbook of Psychiatry and the Law* 2 (1982).

PART C
DETENTION BY LAW ENFORCEMENT OFFICERS

Most jurisdictions allow a law enforcement officer to take a person into custody and transport him or her to a mental health facility if the officer believes that immediate mental health intervention is necessary to protect that person or others from harm. The public is accustomed to calling on law enforcement officers for assistance with mentally disturbed persons, public inebriates, and other persons perceived to be problems, because law enforcement officers provide free, around-the-clock service, because they are mobile and respond quickly, and because they have the legal authority to remove the persons by means of criminal arrest or emergency commitment. In emergency situations, where swift action may be justified to prevent serious harm, custody and involuntary detention of a respondent by a law enforcement officer or crisis intervention team usually precedes any thorough review of the grounds for involuntary civil commitment. Common sense and expediency typically prevail.[1]

In nonemergency cases, at least some review of the allegations and evidence supporting involuntary civil commitment is made before a law enforcement officer takes a respondent into custody and detention in response to a court order. Typically, in such cases, following some judicial or administrative review, a county sheriff[2] is ordered to take a respondent into custody and transport him or her to a mental health facility.

Especially in emergency cases, but also in nonemergency cases where the type of prehearing screening provided by the guidelines in Part B is not undertaken, law enforcement officers may be the first and foremost mental health resource available to a respondent. They play a major role in crisis management and referral of mentally disordered individuals to mental health care and social services.[3] As one commentator noted, they are summoned at times when something "ought not to be happening, and about which someone had better do something now."[4] However, their role may be limited, because law enforcement officers typically are not trained, nor have they been charged with the duty, to perform the necessary evaluation and treatment or to provide habilitation services for respondents.5 Often, law enforcement officers experience difficulties in handling mentally disturbed persons both in assisting such persons themselves and in referring them to mental health or social service agencies that can provide the appropriate help. These officers may be hampered by a lack of information about the types of human service agencies in the community and procedures for contacting them.

The seven guidelines in Part C, listed by title below, recognize the pivotal role of peace officers in the early stages of involuntary civil commitment. They call for better understanding and access to mental health and social services by law enforcement officers by encouraging contacts with local screening agencies. They provide guidance in the manner in which mentally disordered persons should be handled by law enforcement officers. Importantly, they encourage cooperation and better coordination between law enforcement agencies and mental health agencies. Finally, this part calls for more and better training to improve law enforcement's response to mentally disordered persons.

C1. Contact with Screening Agency

C2. Manner of Taking Custody

C3. Explanations Made to the Respondent

C4. Transfer to Mental Health Agency Responsibility

C5. Release from Custody and Transportation Provisions

C6. Prompt Notifications

C7. Training of Law Enforcement Personnel

Shortly before this guidebook was completed, the Police Executive Research Forum published a monograph resulting from a study of police handling of mentally ill persons. As a complement to the guidelines contained in Part C, this monograph is recommended to the reader interested in improving police response to mentally ill persons.[6]

As is true of most of the guidelines contained in this volume, the guidelines in Part C are not intended as models for legislation. Although legislative guidance to law enforcement officers regarding the proper response to mentally disturbed individuals may be very important -- if for no other reason than because police are involved in the great proportion of commitment cases, especially in urban areas -- these guidelines are not primarily intended to guide legislative reform, but rather to shape practices within existing statutory frameworks.[7]

Notes

1. State laws vary considerably in the degree to which the grounds for initial custody and detention differ from the substantive criteria for involuntary civil commitment. Some states require that the same substantive criteria, but a lower burden of proof, be met at the time of custody-taking and detention as at the time of the adjudication of commitment. For example, statutes in Iowa and Ohio require sufficient "reason to believe," "reasonable grounds," or "probable cause" to support custody-taking and initial detention. Iowa Code

Ann. § 229.11 (West 1985); Ohio Rev. Code Ann. §§ 5122.10-.11 (Page 1981). The laws of a minority of states provide for different grounds for initial detention and for commitment. In New Jersey, for example, involuntary detention is allowed if a temporary court order for judicial commitment is not obtainable. N.J. Stat. Ann. § 30:4-38 (West 1981). The New York emergency admission statute provides that a person may be involuntarily hospitalized for up to fifteen days if the person is alleged to have "a mental illness for which immediate observation, care, and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or others." N.Y. Mental Hyg. Law § 9.39 (McKinney Supp. 1986).

2. *See, e.g.*, Ill. Ann. Stat. ch. 91 1/2, § 3-605 (Smith-Hurd Supp. 1985); Ohio Rev. Code Ann. §§ 5122.10-.11 (Page 1981).

3. *See generally Mental Health and Criminal Justice* 155-98 (L. Teplin ed. 1984); Monahan, Caldeira, & Friedlander, *Police and the Mentally Ill: A Comparison of Committed and Arrested Persons*, 2 Int'l J.L. & Psychiatry 509 (1979).

4. Bittner, *Florence Nightingale in Search of Willy Sutton: A Theory of the Police*, in *Potential for Reform of Criminal Justice* (H. Jacob ed. 1971).

5. *See* American Bar Association, *Standards for Criminal Justice*, ch. 7, Part II (2d. ed. 1980).

6. G. Murphy, Special Care: *Improving the Police Response to the Mentally Disabled* (Police Executive Research Forum, 1986). This monograph was the result of a yearlong study of the procedures by which police and mental health agencies handle the mentally ill. It is divided into two parts. Part 1, consisting of chapters 2 through 4, is largely descriptive. Chapter 2 examines the background of the deinstitutionalization movement, the legal criteria for involuntary commitments, the types of mentally ill persons found in the community, the plight of the homeless mentally ill, and whether the mentally ill are more criminally prone than the general population. Chapter 3 examines current practices by law enforcement agencies. Chapter 4 describes how joint law enforcement-mental health response systems have been developed in three communities: Madison, Wisconsin, Galveston County, Texas, and Birmingham, Alabama.

Part 2, consisting of chapters 5 and 6, offers a planning guide for police managers. It details the planning, development, and implementation of a response strategy that reflects the needs of the local community.

Additionally, the monograph presents helpful information in its appendices. For example, appendix A surveys the involuntary commitment criteria for each state. Appendix D presents the guide to police response to the mentally ill developed by the Madison, Wisconsin, Police Department. Appendix E presents exemplary directives and officer referral cards used by various police departments; these examples give the reader the opportunity to examine the actual policies of police departments concerning police encounters with the mentally ill. Appendix F provides a sample assessment questionnaire for police operators, dispatchers, and patrol officers. This questionnaire should aid police officials in assessing situations involving mentally ill persons. Finally, appendix G lists suggests training materials for police departments.

7. Other works, like the Criminal Justice Mental Health Standards (approved by the American Bar Association in August of 1984 and incorporated within the second edition of the ABA's *Standards for Criminal Justice, supra* note 5), recommend relatively broad changes in statutes governing the handling of mentally ill persons by police. *Cf.* standard 7-2.1 (outlining the classes of people subject to police emergency detention). Much broader in scope than the guidelines proposed here, standard 7-2.1 contemplates emergency detention of people "in immediate danger of starvation, frostbite, or hypothermia" as well as the mentally ill.

C1. Contact with Screening Agency

The role of law enforcement officers in handling mentally disturbed individuals is a difficult one, even when the presenting problem and its resolution seem apparent. When standards and procedures for apprehending and transporting a mentally ill person to a mental health or social service facility are not clear, law enforcement officials may make dispositional decisions that are likely to have negative consequences for the individual as well as for the mental health and justice systems as a whole.

(a) Local law enforcement agencies should encourage all officers who encounter individuals suspected to be mentally disturbed to seek assistance from screening agencies or a specified mental health screening officer designated as primary referral points.

(b) When a law enforcement officer has determined that an individual whom he or she has encountered is a fit subject for involuntary civil commitment, the officer should, whenever possible, contact the appropriate screening agency and confer with a mental health screening officer, in person or by telephone, before transporting the individual to a mental health facility. The purpose of this action is to inform the mental health screening officer of the location and apparent condition of the individual and to permit the screening process, provided by the guidelines in Part B, to be initiated.

Commentary

Guideline C1 provides that a local screening agency operate as the point of entry into the mental health system for respondents apprehended by law enforcement officers. The recommended procedures are intended to benefit both the respondent and law enforcement personnel. They are aimed to balance several competing interests – e.g., public safety, timely treatment, and efficiency – that exist in the early stages of involuntary civil commitment.

In order to further cooperation between law enforcement agencies and screening agencies, joint guidelines for the implementation of the jurisdiction's emergency detention procedures should be developed.[1] Such guidelines, if widely disseminated and followed, would help ease confusion over roles and other problems between law enforcement and mental health authorities and thus lead to a more efficient system.[2] Such joint guidelines should provide for some communication between the law enforcement officer at the scene and the mental health official when detaining a mentally disturbed individual. Ideally, the mental health official should make the decision regarding whether the person ought to be taken into custody pursuant to involuntary civil commitment.[3] Where possible, the law enforcement officer may summon the mental health screening officer to the scene in order to make this determination.[4]

The guideline provides that even in circumstances that

do not permit the screening agency to screen a respondent before the respondent is transported to a mental health treatment facility, contact with a mental health screening officer should be made. The contact between a law enforcement officer and a mental health screening officer, even if only accomplished by telephone,[5] has several advantages. First, the police-screener contact alerts police to important issues in dealing with the respondent at the time of the encounter, as well as in handling similar encounters in the future.[6] Second, the contact facilitates decisionmaking about the best options among several available to the police officer, including the following: (a) advising the individual to seek help on a voluntary basis and referring him or her to the appropriate care or service facility to seek such help, (b) convincing the individual to undergo screening by a screening agency on a voluntary basis, (c) taking custody of the individual and transporting him or her to a screening agency for mental health screening on an involuntary basis, and (d) taking custody of the respondent and transporting him or her to a mental health facility for emergency mental health treatment.[7] Third, the police-screener contact ensures that if option (c) or (d) is taken, the facility will be willing to receive the respondent, thereby eliminating the need for the police officer to "make the rounds," searching for a facility willing to receive the respondent.[8]

Notes

1. *See* American Bar Association, *Standards for Criminal Justice*, ch. 7, § 2.2 (1980).

2. *Id*. A number of law enforcement-social service agency agreements that may serve as models for such guidelines were recently described by Abt Associates. *Law Enforcement/Social Service Agency Agreements* (Draft Report, National Institute of Justice, Contract No. NIJ J-LEAA-001-81, April 1986). *See* Guideline B1, "Screening Agency," note 23 and accompanying text.

3. American Bar Association *supra* note 1, at standard 7-2.1.

4. American Bar Association *supra* note 1, at standard 7-2.4.

5. At least one state expressly provides for such police-screener contact by telephone. Ariz. Rev. Stat. Ann. § 36-524 (D), (E) (Supp. 1985).

6. *See* Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 Am. Psychologist 794 (1984).

7. *See In re Harris*, 98 Wash. 2d 276, 654 P.2d 109 (1982) (en banc), where the Supreme Court of Washington suggested that the exploration of such options at the *early stages* of commitment meets due process requirements and is in the best interests of the respondent. "The exhaustion of less restrictive alternatives to involuntary 72-hour detention is essential both to due process and to the integrity of our mental health system. The best interests of the mentally ill lie more often than not in treatment that does not involve commitment." *Id*. at __, 654 P. 2d at 115.

8. *See* Teplin, *supra* note 6, at 800.

C2. Manner of Taking Custody

Police custody can have a traumatic effect on a person, even under the best of circumstances. Law enforcement officers who apprehend mentally disordered persons should proceed in a manner that minimizes negative effects on the persons being taken into custody.

After a law enforcement officer has determined that it is necessary to take a person into custody for the purpose of screening or emergency treatment, and preferably after the officer has contacted a mental health screening agency, the officer should take the person into custody in the most humane, least conspicuous, and least disruptive manner possible. All efforts should be made to safeguard the physical and mental well-being of the respondent and others. Officers should also take reasonable precautions to protect the property of the respondent.

Commentary

Guideline C2 urges that when taking a respondent into custody, a law enforcement officer or crisis intervention team should minimize the stress on and embarrassment to the respondent and should use the least amount of force necessary. This is consistent with law[1] and standard police operating procedures.[2]

The guideline does not preclude the use of restraints in some circumstances, but it does suggest that they be used only when necessary to protect the respondent or the persons taking the respondent into custody.[3] Similarly, it does not preclude taking a person into custody in a public setting, but it does preclude making an example of the respondent or treating the respondent as if he or she had committed a criminal offense. In addition, the guideline urges that reasonable efforts be made to protect the respondent's property. For example, the officer would allow the respondent to lock the door of his or her residence or car or to notify a relative, friend, or neighbor before custody.[4]

Notes

1. *See, e.g.*, Ariz. Rev. Stat. Ann. § 36-508 (Supp. 1985) (a patient's personal property which cannot be used at the institution shall be placed under the control of the patient's guardian, conservator, or, if none, spouse or next of kin; if none of these people are available, the property shall be stored by the mental health agency or protected by appropriate court order); Cal. Welf. & Inst. Code § 5153 (West 1984) (officers shall dress in plain clothes and travel in unmarked vehicles); *Id*. § 5156 (unless a responsible relative, guardian, or conservator is in possession of the person's personal property, the person taking him or her into custody shall take reasonable precautions to safeguard such property); Colo. Rev. Stat. § 27-10-106(8) (1982) (the peace officer shall take reasonable steps to preserve and safeguard the personal property of a patient unless a responsible relative is in possession); Minn. Stat. Ann. § 253B.10(2) (West 1982) (the peace officer who provides the transportation shall not be in uniform and shall not use a vehicle visibly marked as a police vehicle); Ohio Rev. Code Ann. § 5122.10 (Page 1981) (every reasonable and appropriate effort shall be made to take persons into custody in the least conspicuous manner possible); *see also In re Harris*, 98 Wash. 2d 276, 654 P.2d 109 (1982) (en banc) (even a short period of involuntary detention constitutes a massive curtailment of liberty and can have injurious effects on a respondent).

2. American Bar Association, *Standards for Criminal Justice*, standard 7-2.4 (2d ed. 1980). A recent study concluded that police officers generally handled mentally disabled persons in an "impressive" manner in that "in many cases the officer is one of the few protectors a chronic patient may have." *Cop on the Beat Is Unsung Friend of the Mentally Ill Citizen*, ADAMHA News, Mar. 1982, at 6, cited in Stromberg & Stone, *A Model State Law and Civil Commitment of the Mentally Ill*, in American Psychiatric Association, *Issues in Forensic Psychiatry* 57, 100 (1984).

3. *See* American Bar Association, *supra* note 2, standard 7-2.4(a) (recommending that police should use only "the force reasonably necessary to effect such custody").

4. *See* Stromberg & Stone, *supra* note 2, at 100.

C3. Explanations Made to the Respondent

Fear of the unknown may debilitate a respondent who is being taken into custody and exacerbate his or her mental disorder. Upon apprehension, law enforcement officers should identify themselves and inform a respondent why he or she is being taken into custody, where he or she will be transported, and what will happen once he or she is there.

(a) Upon taking a respondent into custody, a law enforcement officer [or other person authorized to detain respondents] should give the respondent the following information:

(i) the officer's name, professional designation, and affiliation;

(ii) the reasons for, nature of, and possible consequences of custody;

(iii) the location to which the respondent is to be transported; and

(iv) the fact that a mental health screening officer or admissions staff member of a mental health facility will explain fully to the respondent his or her legal rights after arrival at the facility.

(b) The above information should be provided to the respondent in a manner that the respondent is most likely to comprehend and to appreciate.

Commentary

Guideline C3 is intended to reduce to the greatest extent possible the stress and uncertainty of a respondent taken into custody. It recommends that when a law enforcement officer or a crisis intervention team takes a respondent into custody to be transported to a screening agency or treatment and care facility, the person taking custody should give the basic orienting information that anyone in a similar position would want and expect. Specifically, it provides that the persons taking custody identify themselves and that they briefly explain what they are doing, why they are doing it, and where the respondent is being taken and for what purpose.[1] In addition, it suggests that the respondent be advised that he or she has certain legal rights that will be explained at the screening agency or treatment and care facility.[2] The information should be presented in a way the respondent is most likely to comprehend and appreciate, taking into account any language difficulties that the respondent makes known or that may be obvious.

Although some respondents will be too ill, disoriented, or anxious to understand the information being offered, the fears of many respondents will be somewhat eased if not by the information itself then by the effort to deal with them in a humane and considerate manner. Once a standardized procedure has been developed and law enforcement officers or crisis intervention team members have received the appropriate training, implementation of this guideline in individual cases should be relatively straightforward.[3]

Explanations provided in Guideline C3 (as well as any other notices or explanations provided pursuant to any other guidelines) should be in the language, mode of communication, and terms that the respondent is most likely to understand. In too many instances, respondents do not comprehend what is happening to them, not because they are unable to understand but rather because no one has made the effort to present the information in a manner that is intelligible to them.[4] In communicating with a respondent, police officers or mental health professionals should take into account any language difficulties that are obvious or that the respondent makes known to them.[5]

Notes

1. *Cf.* American Bar Association *Standards for Criminal Justice*, standard 7-2-4 (2d ed. 1980).

2. Federal courts have recognized the individual's important stake in receiving prompt, adequate notice of rights in civil commitment proceedings. "Since effective notice is a prerequisite to the exercise of an individual's other due process rights, mandatory notice must itself be a requirement of due process." *Doremous v. Farrell*, 407 F. Supp. 509, 515 (D. Neb. 1975). *See also* Institute on Mental Disability and the Law, *Provisional Substantive and Procedural Guidelines for Involuntary Civil Commitment*, at II-17 (1982).

Although most states require notification of rights, they differ in when, how, and by whom, such notification must be given. New York law requires that immediately upon a respondent's admission to a hospital or conversion to a different patient status (e.g., from voluntary to involuntary status), the hospital director must inform the respondent in writing of his or her status, of his or her rights, and of the availability of New York's Mental Health Information Service to assist the respondent. N.Y. Mental Hyg. Law § 9.07(a) (McKinney Supp. 1986). In Iowa, an attorney who is assigned to the respondent is required to explain available rights, as well as the nature and the likely consequences of the proceedings. Iowa Code Ann. § 229 App., Rule 18 (West 1985). California law is particularly specific. Each person who is taken into custody for seventy-two-hour "holds" (for emergency treatment and evaluation) must be given the following information by the authorized person who takes the respondent into custody:

(1) the name, professional designation (police officer, mental health professional), and agency affiliation of the person who takes the allegedly mentally ill individual into custody;

(2) the fact that the custody-taking is not a criminal arrest;

(3) the fact that the person is going to be taken for examination by mental health professionals at a specified mental health facility identified by name;

(4) the fact that legal rights will be explained by the staff of the mental health facility to which the person will be taken; and,

(5) if the person is taken into custody at his or her residence, the fact that he or she may bring along a few personal items, make a telephone call, and leave a message for friends and family.

Cal. Welf. & Inst. Code § 5157 (West 1984).

3. *See* Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, in American Psychiatric Association, *Issues in Forensic Psychiatry* 57, 106 (1984).

> In initiating treatment of severely mentally disturbed persons, the patient's interest in learning his rights, though important, may not be paramount. Harm could result from administering a long description of legal rights to an agitated, frightened patient who, for the next few hours needs a different kind of therapeutic interaction. Thus, the Model Law requires telling a patient his rights "as soon after admission as his medical condition permits." Often this may be done shortly after admission and, in almost all cases it should occur within four to twelve hours. This advice should be viewed as a therapeutic exchange, an effort to explain to the patient what is occuring and why. The dialogue should not degenerate into a routine incantation read from a card, like the "Miranda" warnings given to persons taken into criminal custody.

Id.

4. Sales, Powell, & Van Duizend, *Disabled Persons and the Law: State Legislative Issues* 597 (1983).

5. For example, an explanation . . . in English to a respondent who understands only Spanish [or] Vietnamese . . . is of little use whether or not that individual is . . . [mentally disabled]. Attempting to communicate verbally or through a standard printed form to someone who can only understand sign language or read braille, or couching an explanation in technical . . . terms is equally futile.

Id.

C4. Transfer to Mental Health Agency Responsibility

Once a law enforcement officer [or other person authorized to detain respondents] has conferred with a mental health screening officer as provided for in Guideline C1 and has taken the respondent to the screening agency or treatment and care facility identified by the screening officer, that agency or facility should accept the respondent for short-term, involuntary mental health evaluation and care. The law enforcement officer or other authorized person should be free to leave after completing a screening application and conferring briefly with admission staff of the agency or facility.

Commentary

Guideline C4 provides for a "no decline" policy or agreement between law enforcement agencies and facilities authorized to detain respondents pending civil commitment hearings. Such a policy[1] has been established in Chicago[2] and has been considered in New York City[3] to reduce the reluctance of police officers to intervene in emergency mental health cases. This reluctance stemmed from instances in which hospitals declined to examine a respondent and directed the officers to transport him or her elsewhere or in which officers were required to remain at a hospital for unduly long periods of time while a screening decision was being made.[4]

Although the guideline makes it easier for law enforcement officers and crisis intervention teams to leave a respondent at a treatment and care facility or screening agency, it includes provisions to protect against misuse of the no-decline policy and "dumping" of troublesome individuals at the emergency room door. First, the transporting officer or crisis intervention team must confer with a mental health screening officer in accordance with Guideline C1 to determine whether screening is necessary and, if so, to what screening agency or treatment and care facility the respondent should be taken. Second, the officer must complete the sections of the screening application that require a description of the overt acts, specific threats, or other circumstances that suggest that the respondent may meet the criteria for for involuntary civil commitment, as well as the names of persons who may have additional information regarding the respondent and his or her actions.[5]

Once the appropriate sections of the application have been completed, a police officer or crisis intervention team member may, but is not required to, leave to return to his or her duties. When a respondent's conduct makes him or her subject to a criminal charge that would be pressed,[6] the police officer who transported the respondent to the facility should remain until an admission decision has been made[7] or, alternatively, make an arrangement with the screener or other mental health professionals whereby the officer would leave but would return if the respondent would be released by the facility. In the absence of such an arrangement, if the screening agency or mental health facility determines that the person does not meet involuntary civil commitment criteria, they may still wrongfully detain and hospitalize that person because there may be no expedient manner to transfer custody of the person to the criminal justice system and because of a fear of liability risk and adverse publicity that would attend the discharge of a dangerous person.[8]

A no-decline policy enabling police officers to leave a respondent at a facility should be implemented in a particular case only if the facility itself is properly authorized under the law of the jurisdiction to detain respondents pursuant to involuntary civil commitment proceedings. In most jurisdictions, the department of mental health designates facilities to have this authority,[9] and screening agencies should be so designated. In jurisdictions that statutorily prescribe categories of facilities to have this authority,[10] a screening agency might be located within an authorized facility or, although this is not encouraged, a statutory amendment granting screening agencies this authority might be sought. Alter-

natives are for the mental health screening officer to direct the police officer to an authorized facility or for the police officer to transport the respondent to the screening agency but remain until the screening officer recommends what actions the police officer should pursue.

A no-decline policy or agreement may not be possible in jurisdictions that statutorily impose additional requirements on applicants or transporting officers. In states in which it may be used, however, such a policy, within the limits noted above, is a practical and efficient means of ensuring that respondents who require emergency services receive them, while protecting against possible misuse.

Notes

1. Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rates of the Mentally Ill*, 39 Am. Psychiatry 794, 801 (1985) (the conclusion reached after a recent study of 1,382 police-citizen encounters was that "[n]o-decline agreements are vital for establishing a successful liaison between police departments and the mental health system").

2. J. Zimmerman, *Involuntary Civil Commitment in Chicago* 37 (1982).

3. W. L. Fitch, B. D. McGraw, J. Hendryx, & T. B. Marvell, *Involuntary Civil Commitment in the First Judicial Department, New York City* 17, 24 (rev. ed. 1982).

4. *See supra* notes 2 & 3; *see also* American Bar Association, *Standards for Criminal Justice*, ch. 7, § 2.1 (2d ed. 1980) (the general reluctance of police to become involved in noncriminal situations is heightened when referrals are not accepted, because police intervention appears to be a meaningless gesture).

5. *See* Guideline C2; *cf.* Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 Harv. J. on Legis. 275, 316 (1983) (the proposed state law states in part, at section 4.3, that "[u]pon presenting a person to a treatment facility, the police officer shall inform the staff in writing of the facts that caused him to take the person into custody . . .").

6. *See* American Bar Association, *supra* note 4, §2.5. (Police normally have the discretion to proceed either civilly or criminally in situations where a detained person has shown signs of mental disturbance and criminal activity. Due to familiarity and convenience, police have traditionally preferred the criminal process. However, the civil process is recommended for minor offenses, because in these situations the need for treatment outweighs the severity of the offense. When the individual is suspected of having committed a serious crime, the need for immediate and secure custody is greater than the need for immediate treatment. Thus, the criminal process may be best for mentally disturbed people who commit serious crimes.).

7. *See* Stromberg & Stone, *supra* note 5, at 319; J. Zimmerman, *supra* note 2, at 37.

8. *See* Huber, Roth, Appelbaum, & Ore, *Hospitalization, Arrest, or Discharge: Important Legal and Clinical Issues in the Emergency Evaluation of Persons Believed Dangerous to Others*, 45 L. & Contemp. Prob. 99 (1983).

9. *E.g.*, Cal. Welf. & Inst. Code §5150 (West 1984); Wis. Stat. Ann. §51.15(2) (West Supp. 1985).

10. *E.g.*, N.Y. Mental Hyg. Law § 9.39(a) (McKinney Supp. 1986); *see also* Ill. Ann. Stat. ch. 91 1/2, §§ 3-606, 1-114(Smith-Hurd Supp. 1985).

C5. Release from Custody and Transportation Provisions

A person who is released from custody by a law enforcement officer and who is not admitted to a mental health facility on a voluntary or involuntary basis should not be left to return home without assistance.

If a respondent is found not to require admission as a voluntary or an involuntary patient and is not subject to criminal arrest, the mental health screening officer or the treatment and care facility admissions staff should arrange to take the respondent home or to some other place in the community requested by the respondent.

Commentary

Guideline C5 concerns a point in the commitment process at which the continuum of services and cooperation among law enforcement agencies and mental health agencies often breaks down. In many jurisdictions, little provision is made for the transportation of respondents who have been brought in under emergency detention and are found not to require admission.[1] Sometimes facility staff ask police officers who transport respondents to the facility to provide what is in essence a taxi service by taking respondents home.[2] In other instances, the respondent is left to find his or her own way back, possibly from a distant and unfamiliar part of town.

Guideline C5 provides that when a person is not admitted for care and treatment and is not subject to police custody because of a possible criminal violation, he or she should be transported back to where he or she was apprehended or requests to be taken. Further, it assigns the responsibility for arranging for a respondent's transportation to the mental health screening officer or the facility admissions staff, and it requires that when a friend or family member is not available to transport the person and he or she does not have the necessary bus or cab fare, facility or agency funds should be used.[3] Implementation of these procedures is particularly important in light of the provision in Guideline C4 for a no-decline policy. Although it is not anticipated that mental health screening officers frequently will have to arrange rides for respondents, this guideline should help correct a current inequity in the system without great public expense.[4]

Notes

1. Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 Harv. J. on Legis. 275, 387 (1983).

2. *See* American Bar Association, *Standards for Criminal Justice*, ch. 7, § 2.1 (police authority to transport mentally ill and mentally retarded people is inextricably bound up with the substantive authority of the state to civilly commit); *see also* N.C. Gen. Stat. § 122C-266(a) (4) (Supp. 1985) which requires "the law-enforcement officer or other person designated to provide transportation" for the released respondent to the originating county.

3. *See* American Bar Association, *supra* note 2. In the commentary to standard 7-2.3, providing for a law enforcement policy preference for voluntary disposition of a case involving mentally disordered individuals, the American Bar Association recognized the

necessity for cooperation among police and mental health personnel in arranging transportation for persons no longer under police custody.

> Whenever practicable, the police should seek a voluntary disposition of a situation involving the mentally or mentally retarded person before seeking to effect custody against the will of that person.
>
> Custodial intervention, even though for the benefit of the person to be detained, nonetheless involves a substantial infringement of liberty. In some cases, it may be possible to summon friends or relatives of the mentally ill or mentally retarded person to the scene, or to transport the person to the person's business or residence. This is especially desirable when the mentally ill or mentally retarded person is already under professional care, has not committed a crime and does not otherwise appear dangerous. An officer's special awareness of and familiarity with appropriate community mental health and mental retardation resources will assist in finding alternatives to emergency hospitalization.

Id. (notes and subheadings omitted).

4. Procedures consistent with the guideline are used currently by at least one hospital in Chicago. *See* Van Duizend & Zimmerman, *The Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, 33 De Paul L. Rev. 225 (1984).

C6. Prompt Notifications

Especially in the early stages of involuntary civil commitment, when the lines between appropriate civil and criminal proceedings are blurred, special care should be taken by law enforcement officers and screening agency personnel to balance the need for prompt communications regarding the respondent's condition and whereabouts with the need to safeguard the respondent's right to privacy.

(a) Unless a respondent objects after being asked permission, the mental health screening officer or treatment and care facility admissions staff should notify the respondent's next of kin, or other individuals identified by the respondent, of the respondent's whereabouts, the reasons the respondent was taken into custody, the respondent's current status, and whether involuntary civil commitment proceedings have been or will be initiated.

(b) The success of a program of treatment and care and, ultimately, the well-being of the respondent depend largely on knowledge about the course of any previous treatment. If a respondent is or recently has been receiving mental health or social services when taken into custody, the mental health screening officer or treatment and care facility admissions staff should contact, with the respondent's consent, the providers of those services to obtain the information needed for a prompt evaluation and treatment of the individual.

Commentary

Optimally, access to information about a respondent should be granted to individuals only with the respondent's consent and otherwise only to professional personnel who have undertaken the responsibility for the respondent's immediate involuntary care. In practice, it is most difficult to balance a proper respect for the confidentiality of a respondent's treatment records and his or her right to privacy with the legitimate needs of other people to know about the respondent's whereabouts, current condition, and circumstances. The difficulty of finding the proper balance is exacerbated by several factors: (a) legitimately memorialized records, which may be commingled with arrest records;[1] (b) differing regulations governing confidentiality and disclosure of information promulgated by various components of the mental health-justice system; (c) disclosures that may be authorized by the criminal or civil code;2 and (d) the exigencies of handling mentally disturbed individuals under the press of time.

Guideline C6 recognizes that sharing of information about a respondent among individuals and agencies with a legitimate need to know can be most beneficial, especially when it is done with the permission of the respondent. However, the guideline acknowledges that serious breaches of confidentiality can occur when information is shared without due consideration of the respondent's right to privacy. It therefore imposes an obligation upon all professional personnel involved with the respondent to exercise sound professional judgment in their communications about the respondent by avoiding all unnecessary disclosures of information that threaten the confidentiality of records. As a general rule, the prior consent of the respondent to all disclosures of information should be sought.

Notes

1. *See* American Bar Association, *Standards for Criminal Justice* 7-2.9 (2d ed. 1980) (standard and commentary for police and the maintenance of records of contacts with mentally ill or mentally retarded persons).

2. *Id.* at 64-65.

C7. Training of Law Enforcement Personnel

Law enforcement officers are often the first to make contact with mentally disturbed individuals in the community. The identification of and responses to mentally disordered persons and the necessary interaction with mental health and social services providers present special problems for police. In order to address these problems adequately, law enforcement agencies in every jurisdiction should, in cooperation with the community coordinating council (see Guideline A1), develop and present training programs and materials for law enforcement officers regarding the mental health and social service delivery systems. The topics addressed by these programs and materials should include

(a) the nature and manifestations of mental disorders;

(b) appropriate techniques for communicating with and handling mentally disordered persons;

(c) laws (including the scope of potential liability), policies, and procedures established for responding to requests involving mentally disordered persons, obtaining necessary services for them, and taking mentally disordered persons into custody;

(d) policies and procedures for transporting mentally disordered persons to and from mental health and social service facilities;

(e) the scope and quality of resources available to assist mentally disordered persons, including those provided by mental health screening officers and screening agencies; and

(f) the procedures for contacting an appropriate screening agency and the duties and powers of mental health screening officers.

Commentary

As is noted throughout these guidelines and acknowledged in statutes governing involuntary civil commitment procedures,[1] police officers frequently intervene in emergency situations involving mentally disturbed persons.[2] In cases in which police initiate involuntary civil commitment, as in other incidents involving mentally disturbed individuals, police are expected to be the point of first contact and to perform a variety of services not readily available from many other public agencies.[3] As noted by the American Bar Association, "[e]xpectation and necessity frequently require the police to respond even though they may lack specialized training for dealing effectively with the mentally ill and mentally retarded."[4] Thus, it is essential that law enforcement officers have the knowledge and skills necessary to perform the responsibilities imposed on them by statute.

Accordingly, this guideline urges that law enforcement officers be provided with training programs and materials regarding (a) how to recognize and handle mentally disturbed persons, (b) the assistance available from the mental disability and social services agencies in their jurisdiction, and (c) applicable principles, policies and procedures.[5] The intent of this guideline is not to make police officers into mental health or social work professionals. Rather, it is to assist officers in carrying out their duties as effectively as possible and to help ensure that persons requiring emergency services receive them quickly and with the least limitation of liberty.

Both preservice and in-service training should be provided to all law enforcement officers, including those serving in custodial facilities. Police who are members of special mental health emergency units should receive more intensive training, but all line officers should receive the basic information listed in the guideline, because even nonspecialists are likely to encounter mentally disabled persons during the course of their duties. The preservice training should cover all of the points noted in the guideline. The in-service training should be designed to keep officers up-to-date on the laws, policies, and procedures pertaining to, and services available for, mentally disabled persons who present a danger to themselves or others. Both training programs should be practically oriented, providing officers with clear "how-to's" rather than general information and abstract ideals.

The guideline recommends that the community coordinating council serve as a resource for local law enforcement agencies in developing, selecting and obtaining written training materials and expert instructors. For example, members of the council might identify professionals in their agencies who are qualified and willing to provide training classes or to write or review training materials. The number of hours and frequency of the training will vary, depending on the resources available and the size of a jurisdiction. Some states may, however, consider developing a statewide training package or setting some minimum standards to assure that high-quality training is available throughout the state.

Notes

1. *E.g.*, Cal. Welf. & Inst. Code § 5150 (West 1984); N.Y. Mental Hyg. Law § 9.41 (McKinney Supp. 1986); N.C. Gen. Stat. §122C-262 (Supp. 1986); Wis. Stat. Ann. § 51.15(1) (West Supp. 1985).

2. *See* Bittner, *Police Discretion in Emergency Apprehension of Mentally Ill Persons*, 14 Soc. Probs. 278 (1967); Teplin, *Criminalizing Mental Disorder: The Comparative Arrest Rate of the Mentally Ill*, 39 Am. Psych. 794 (1984) (noting that handling mentally disordered persons is a routine responsibility of law enforcement officers).

3. *See* I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 16-17 (1983).

> An officer does not necessarily have to witness the behavior warranting emergency detention, but may initiate emergency detention on the basis of reliable information reported by an eyewitness. The officer need only believe that the informant is a reliable source. The officer, in effect, serves as the agent through whom proceedings are initiated. There have been reports that officers in Milwaukee have in the past refused to detain mentally ill persons because they did not actually observe the dangerous behavior themselves. Whether every law enforcement officer in Milwaukee County is aware of his or her authority to act on the reliable report from an eyewitness, and will in fact do so if the situation should arise, is a question that is far beyond the scope of this report. However, interviews with several police officers and others familiar with police work, suggested that officers are generally aware of their authority in emergency detentions and will refuse to detain a person only if they believe that the person does not meet statutory criteria for emergency detention. . . .
>
> An officer has four basic options when confronting a mentally aberrant person who he or she believes is exhibiting strange or frightening behavior: (1) criminal arrest, (2) emergency detention pursuant to Section 51.15 of SMHA, (3) referral of the "complainants" to the Protective Services Management Team or the Office of Corporation Counsel for filing of a formal petition for examination of the person pursuant to involuntary com-

mitment (51.20); or (4) referral to some other service or facility (e.g., Crisis Intervention Service). The present law, it seems, allows individual officers to exercise discretion, make moral judgments, and react compassionately to situations.

4. American Bar Association, *Standards for Criminal Justice*, Part II, Introduction (2d ed. 1980).

5. *See id*. at 7-2.8; Teplin, *supra* note 2, at 801 (as a matter of public policy, police officers must receive adequate training in recognizing and handling mentally disordered persons, "such that persons who are more disordered than disorderly may be handled humanely and channeled through the most appropriate system.").

PART D
MENTAL HEALTH EXAMINATION, TREATMENT, AND DISPOSITION BEFORE JUDICIAL HEARING

The preceding two parts of this guidebook dealt in roughly chronological fashion with a person's initial contact with the involuntary civil commitment process, including assessment by a mental health screening officer and detention by law enforcement personnel. Part D addresses issues surrounding the major events and procedures in the involuntary civil commitment process before a commitment hearing but after the involvement of law enforcement and mental health screening agencies. These events and procedures include prehearing examination, short-term mental health treatment and care, diversion, and release of persons who have become subjects of commitment proceedings. In most commitment cases, they take place while a respondent is detained in a hospital, even though most state mental health laws permit a respondent to be released pending a court hearing on commitment.

State mental health laws vary in their provisions governing the procedures in the commitment process after a respondent is taken into custody and detained but before court review of commitment. Most state laws require that the facility admitting a respondent on an involuntary basis first make a threshold determination of whether detention and involuntary mental health care are warranted and that it release the respondent if they are not. Release at this stage is usually unconditional. As noted above, it is rare that a respondent is released from a mental health facility pending the outcome of a judicial review of his or her commitment.[1] Once this threshold detemination is made, most state statutes provide for one or more mental health examinations of the respondent's suitability for involuntary mental health care. In a few states, respondents are entitled to an examination, at state expense, by an examiner independent of those appointed by the court.[2] The results of these examinations are used to inform short-term and long-term treatment decisions and determinations regarding release or diversion of the respondent to voluntary mental health care and related social services, as well as to provide a factual basis for judicial review of commitment. In practice, distinctions among the various examinations are often blurred. That is, the legal requirements for a number of examinations of a respondent during short-term detention and follow-up mental health examination of a respondent pursuant to a commitment hearing may blend with policies governing hospital admission, emergency care, and transfer of a patient to a treatment ward.

Picking up a dominant theme of earlier parts, the guidelines in this part seek to encourage a continuity of care provided to a respondent during the time he or she awaits court review of commitment; to urge cooperation among screening agencies and other community services, inpatient mental health facilities, and the courts; and to promote a view of involuntary civil commitment that eschews "all or nothing" and "once and for all" decisionmaking and acknowledges the possibility (if not the practical availability) of a continuum of services available to a respondent (see Guideline A2). The guidelines embody the belief that such cooperation and an expansive view of commitment, especially at the prehearing stages, best serve a person's interests in avoiding needless confinement and in receiving adequate care and treatment. At the same time, the guidelines seek to accommodate competing concerns for social safety, responsible use of scarce resources, and avoidance of unnecessary procedural impediments.

Notes

1. *But see* D. Wexler, *Mental Health Law* 79 (1981)

> [I]n some outlying Arizona counties, respondents, unless violent or likely to flee, are seldom detained prior to hearing. One reason given for such a practice was the lack of adequate detention facilities, though generally it was thought that the best interests of the proposed patient would be served by his being in his home surroundings.

Id.

2 .*See, e.g.*, Ill. Rev. Stat. ch. 91 1/2, § 9-3 (Smith-Hurd Supp. 1985).

D1. Responsibilities Assumed by Mental Health Facility

A mental health facility assumes a responsibility for the well-being of a respondent admitted for the purposes of involuntary mental health evaluation and care until such time as the respondent is unconditionally released from the facility or chooses to become a voluntary patient. This responsibility is not lessened by the pendency of a commitment hearing.

(a) Once a respondent has been presented to a designated mental health facility by a mental health screening officer or a law enforcement officer, facility staff should promptly examine the respondent to make a preliminary assessment of the respondent's problems and needs, determine whether the person meets the statutory commitment criteria, and make tentative plans for providing the person with needed treatment and care.

(b) If the mental health examiner determines that the respondent does not meet involuntary civil commitment criteria, the respondent should be released promptly, but only after suitable arrangements for transportation have been made (see Guideline C5). If the examination reveals a need for mental health or social services, the respondent should be informed of and, if the respondent so desires, referred to appropriate services available in the community.

(c) If the mental health examiner determines that the respondent meets the statutory commitment criteria, the mental health facility should provide, or make the arrangements for other facilities to provide, involuntary mental health care. As a general rule (see Guideline D6), specific types of treatment and care should be provided only with the respondent's consent.

Commentary

Most state statutes empower mental health facilities to assume a fiduciary role *vis-a-vis* candidates who are presented for prehearing examination.[1] This role entails both legal and therapeutic responsibilities.[2] Because of fears of liability for false imprisonment, a reluctance of mental health personnel to make conclusory judgments about a person's alleged "dangerousness," poorly defined professional responsibilities during the phase of prehearing detention, and procedural hurdles associated with involuntary commitment, mental health facilities often do not assume this difficult role. Consequently, unnecessary confinement, premature discharge of a person without provision of needed mental health or social services, and inappropriate delays in treatment and care while the person is "held" pending the outcome of a hearing may result. Mental health facilities are ethically obligated to provide for, or arrange for provision of, appropriate mental health and social services. Notwithstanding the difficulties associated with this dual role, Guideline D1 encourages mental health facilities to assume full responsibilities and perform the duties required by those responsibilities. This includes providing necessary mental health services and determining the legal status and safeguarding the therapeutic and legal interests of persons presented to them for prehearing examination in accordance with good professional practice and existing laws.

Notes

1. *See, e.g.*, Va. Code § 37.1-67.4 (1984) (an institution caring for a person placed with it pursuant to a temporary order of detention is authorized to provide emergency medical and psychiatric services within its capabilities when the institution determines such services are in the best interests of the person in its care). Ill. Ann. Stat. ch. 91 1/2, §§ 3-604, 3-607, 3-704 (Smith-Hurd Supp. 1985).

> A strength of the Illinois system is that the involuntary commitment process may be halted quickly when such a commitment appears to be unnecessary or ill-considered. If either of the two required examiners does not find that the respondent meets the statutorily prescribed criteria, the respondent is immediately released and the case does not proceed to a judicial hearing. If the respondent's symptoms remit during the period of time preceding the judicial hearing, the hospital will discharge the patient. In this situation, if the case has already been set for a hearing, it will be dismissed when it is called. Similarly, if a respondent consents to a voluntary admission, counsel confirms that the decision is indeed voluntary, and the court concludes that such an admission is of benefit to the respondent and the public, the case is dismissed.

Van Duizend & Zimmerman, *The Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, 33 De Paul L. Rev. 225, 250 (1984)(footnote omitted).

2. *See* Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, in American Psychiatric Association, *Issues in Forensic Psychiatry* 59, 105-06 (1984) ("While the Model Law creates broad avenues by which a person's need for treatment may be evaluated, this independent examination requirement provides a check against unwarranted deprivations of the person's liberty.").

D2. Linking Screening with Prehearing Examination

Good information about a respondent's needs and the available resources to meet them is a prerequisite to proper determinations regarding the propriety of commitment and the suitability of mental health care and related social services.

If possible, before reaching decisions about diagnosis, prognosis, and treatment, a prehearing examiner should always review the screening report (see Guideline B7), if one is available, and consult with a mental health screening officer about the mental condition and circumstances of the respondent and the availability of appropriate mental health and social services.

Commentary

Given that only a minority of patients are subjected to prolonged hospitalization,[1] procedures that link inpatient treatment and evaluation programs with other programs along the continuum of services available in the community (see Guideline A2, "Continuum of Services: Directory") are fundamental to good practices in any involuntary civil commitment system. Unfortunately, information about a respondent's condition and circumstances gathered before a prehearing examination often is either unavailable or not used in subsequent stages in the commitment process. Guideline D2 encourages mental health screening officers and persons responsible for prehearing examinations, treatment, and care in mental health facilities to coordinate and share information.

Even in jurisdictions with formal or informal mechanisms for mental health screening, prehearing examiners are often unaware of screening information gathered in the community. Without that information, an examiner must evaluate the person's needs for treatment and provide the first check against improper deten-

tion of the respondent based solely on the presenting party's allegations and the mental health status of the person at the time of the examination. The examiner is faced with a dilemma: he or she must either make a decision about release or continued detention of the respondent based on limited information or postpone the decision until the respondent can be examined again. Neither choice is satisfactory. Guideline D2 recommends a procedure whereby the threshold decisions made at the time of a prehearing examination are based on the best and most complete information.

In reviewing screening reports and in consultations with mental health screening officers, examiners should be sensitive to important issues of confidentiality and disclosure of information. These issues are dealt with extensively elsewhere.[2]

Notes

1. See Kiesler, *Public and Professional Myths about Mental Hospitalization: An Empirical Reassessment of Policy-Related Beliefs*, 31 Am. Psychologist 1323, 1330-32 (1982).

2. See Appelbaum, *Confidentiality in Psychiatric Treatment, in Psychiatry* 325 (L. Grinspoon ed. 1982); E. Beis, *Mental Health and the Law* 205-15(1984); R. Reisner, *Law and the Mental Health System* 202-67(1985); *cf.* 42 U.S.C. §§ 9501(1)(H)-(I) (1982); Alaska Stat. § 47.30.845 (1984); Ark. Stat. Ann. § 59-1416(14) (Supp. 1985); Cal. Welf. & Inst. Code § 5328 (West Supp. 1986); N.M. Stat. Ann. § 43-1-19 (1984); N.Y. Mental Hyg. Law §§ 33.13- .14 (McKinney Supp. 1986); Ohio Rev. Code Ann. § 5122.31 (Page 1981); Pa. Stat. Ann. tit. 50, § 7111 (Purdon Supp. 1985); Tex. Rev. Civ. Stat. Ann. art. 5547-87 (Vernon Supp. 1986).

D3. Explanation of Proceedings and Advice of Rights

Persons receiving involuntary mental health services should be advised of their rights and be told as much as feasible about what is happening to them and why. The manner in which this information should be conveyed varies, depending on the circumstances.

Mental health examiners should explain to respondents the purpose, nature, and likely consequences of the prehearing examination, and the examiner's role, as well as the respondent's rights during the commitment proceedings. Respondents should also be given written descriptions, in an easy-to-read form, of their rights in the facility where they will be retained as involuntary patients.

Commentary

Fairness dictates that persons who are subjected to the involuntary civil commitment process be informed about that process,[1] even if they may not appear to be fully able to appreciate all of the information provided.[2] The issue of explanations provided to mentally disordered persons, especially advice of legal rights and "warnings," raises a red flag for psychiatrists and lawyers alike. Few would argue, however, for a "routinized incantation read from a card, like the `Miranda' warnings given to persons taken into criminal custody."[3] Nor would deception by mental health staff through providing patients with misinformation or no information at all be condoned.[4] Mental health professionals' obligations, based in part on the ethical standards of the professions, require that they provide a full and open disclosure of the purpose, nature, and consequences of the examination in the context of civil commitment process.[5]

Many states require that mental health examinations be accompanied by a notification of rights and a fair explanation of the purpose, nature, and consequences of the examination as well as the commitment proceedings as a whole. New York, for example, requires that immediately upon a person's admission to a hospital, the hospital director must inform the respondent in writing of his or her status, of his or her rights, and of the availability of the Mental Health Information Services for assistance.[6] Wisconsin and Illinois require that a respondent be notified of the right to remain silent during the mental health examination.[7]

According to studies conducted by the Institute on Mental Disability and the Law as part of the first phase of the Involuntary Civil Commitment Project (see Introduction), examiners who make frank disclosures and give accurate explanations report that patients are pleased that an examiner has leveled with them.[8] The effect may be an enhanced atmosphere of trust and cooperation.[9] Rather than cause a respondent to be cautious about responses to the examiners, the explanation may reduce resistances. Many examiners report that patients rarely refuse to talk with them as a matter of legal right, though some may refuse because they are either too hostile or too sick to communicate.[10]

Although it is crucial to stress the importance of the general rule expressed by Guideline D3, both the generality of the rule and the difficulties of implementing it on a case-by-case basis should be acknowledged. Given the mental health examiner's dual role of treatment provider and "quasi-judicial officer" *vis-a-vis* persons with a range of types and severities of mental health problems, a number of aspects of the explanation given in individual cases must be left to the sound professional judgment of the examiner, guided by the general rule expressed in the guideline and applied within the framework of state statutes. The aspects that need to be determined on a case-by-case basis include (a) the precise wording of the explanation[11] (including its length and manner of presentation), (b) its timing[12] (e.g., after a respondent's condition has been "stabilized"), and (c) the frequency of presentation[13] (e.g., once in the beginning or every time a person is examined or observed). For example, an agitated and frightened respondent may fail to appreciate fully an explanation presented to him or her shortly after hospital admission, but may become much more receptive after a few hours.14 This is not to say that

mental health professionals routinely should postpone explanations offered to a respondent until he or she no longer appears agitated. A respondent's demeanor may belie his or her ability to understand and appreciate any explanations provided.[15]

An important consideration regarding the explanations provided respondents presented for prehearing examination is the obligation of examiners not to deceive the respondent into believing that the relationship with the examiner is a protected, confidential doctor-patient relationship. Another consideration is the examiner's duty, imposed by statute in some states,[16] to explain to the respondent that he or she has the right to remain silent and to refuse to answer the examiner's questions. In jurisdictions in which respondents have the right to remain silent during the examinations, mental health examiners are confronted with the dilemma of the "double agent." That is, they are charged with the responsibility of acquiring as much information as necessary to get a complete and accurate picture of the respondent's condition and surrounding circumstances, yet they have an obligation to uphold the respondent's right to remain silent and not to disclose anything that might be used as basis for involuntary civil commitment. In states that require an examiner to explain to the respondent that he or she has the right to remain silent, there may be no easy answer in those few cases in which respondents actually exercise their right to silence. As noted above, warning respondents that anything they say may be used against them in commitment hearings may have little actual impact on respondents' willingness to cooperate with mental health professionals.[17]

As a general rule, an examiner has an obligation not to deceive the respondent into believing that his or her relationship with the examiner is a protected, confidential doctor-patient relationship. In states where statutes impose an affirmative obligation upon examiners to explain the respondents' right to remain silent, the examiner will, of course, need to comply with local law. In any event, the examiner should respond honestly and appropriately if the respondent asks if his or her full cooperation and compliance with the requirements of the examination are required.

In jurisdictions in which examinations routinely are conducted by court-appointed examiners who are independent of the mental health facility where the person is detained, examiners are less burdened by the double-agent problem and may initiate interactions with the person by declaring, "I am not your doctor." The problem is not completely avoided, however, because the examiner retains an ethical obligation to do the person no harm by either commission or omission. This obligation may be focused in the examiner's relationship with the facility, the patient, or both. The mental health facility's administrative policies regarding explanations of rights and procedures to involuntary patients also bear on the advice provided by the prehearing examiner and should comply with the requirements of Guideline D3.

Notes

1. *See Doremus v. Farrell*, 407 F. Supp. 509, 515 (D. Neb. 1975) (notice must include, among other things, the time and location of the hearing, the reasons for detention, and the standards for commitment). *See also* Guideline C3, "Explanations Made to the Respondent."

2. *See* Lidz, Meisel, Zerubavel, Carter, Sestak, & Roth, *Informed Consent: A Study of Decisionmaking in Psychiatry* 326 (1984); Cassileth, Zupkis, Sutton-Smith, & March, *Informed Consent — Why Are Its Goals Imperfectly Realized?* 302 New Eng. J. Med. 896 (1980).

3. Stromberg & Stone, *A Model State Law and Commitment of the Mentally Ill*, in American Psychiatric Association, *Issues in Forensic Psychiatry* 59, 106 (1984).

> Even when the information presented is adequate, therefore, the consenting process may be nothing more than a "ritual" if the patient-subject remains "uneducated and uncomprehending." To avoid this result, the physician could be held responsible for taking reasonable steps to ascertain whether the information presented has been understood, so that if it has not he may supplement it as needed or may convey the same information in a manner more comprehensible to the particular patient.

Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. Pa. L. Rev. 340, 414 (1974).

4. "While instances of physical abuse, coercion, and fraud appear to be less frequent in the modern mental hospital, such abuses are not yet uncommon, and other kinds of overreaching, including deceit, duress, and threat of force, are still documented as regular occurrences." Parry, *Summary, Analysis, and Commentary*, 9 Mental and Physical Disability L. Rep. 162, 163 (1985).

5. *See generally* American Psychiatric Association, *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (1981); American Psychological Association, *Ethical Principles of Psychologists*, 36 Am. Psychologist 633 (1981); American Psychological Association, *Standards for Providers of Psychological Services* (1977); American Psychological Association, *Specialty Guidelines for the Delivery of Services by Clinical Psychologists*, 36 Am. Psychologist 640, 645 (1981); American Psychological Association, *Specialty Guidelines for the Delivery of Services by Counseling Psychologists*, 36 Am. Psychologist 652, 657 (1981); *see also* American Bar Association, *Standards for Criminal Justice*, standard 7-3.6 and commentary (2d. ed. 1980) (discussing procedures for conducting mental health evaluations in the criminal context).

6. N.Y. Mental Hyg. Law ?? 9.07 (McKinney Supp. 1986). *See also* I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* (1983).

> [Wisconsin law] requires that a detention facility director, or his or her designee, orally and in writing, inform a detained person of his or her rights when the person arrives at the facility. These rights include the right to contact an attorney and a member of the detainee's immediate family, the right to appointed counsel if the individual is indigent, and the right to remain silent including that the individual's statements may be used as a basis for commitment. The detainee should also receive a copy of the statement of emergency detention. In accordance with these provisions in the law, upon admission to Ward 53B respondents are interviewed by a member of the Ward 53B staff, orally informed of their legal rights, and provided with a set of written materials setting forth those legal rights. Following the notification of rights, the respondent is asked to sign and date several forms contained in the written materials provided to acknowledge the oral and written notification of rights. . . . The person providing the notification of rights then signs an affidavit of ser-

> vice . . . certifying that the respondent was informed of his or her rights. Finally, the respondent is asked to authorize the Milwaukee Mental Health Complex to acknowledge his or her presence in Ward 53B to parties that may be personally interested in the respondent's whereabouts. A standardized consent form is used for this purpose. . . . The respondent is also asked to sign a consent form directing that persons named by the respondent be given notice in the event of his or her imminent discharge from Ward 53B.

Id. at 58.

7. Wis. Stat. Ann. § 51.15(9) (West Supp. 1985); Ill. Ann. Stat. ch. 91 1/2, § 3-208 (Smith-Hurd Supp. 1985). Failure of the examiner to provide this information will prevent the examiner from testifying at the court hearing regarding the respondent's admission. *Id. See also* Van Duizend & Zimmerman, *The Involuntary Civil Commit-ment Process in Chicago: Practices and Procedures*, 33 De Paul L. Rev. 225, 233 (1984).

8. I. Keilitz, *Involuntary Civil Commitment in Columbus, Ohio* 57 (1982).

9. *See* F. A. Rozovsky, *Consent to Treatment: A Practical Guide* 70-71 (1984) (discussing circumstances where total disclosure of information may have a negative impact on a patient's condition).

10. *See* Miller, Maier, & Kaye, *Miranda Comes to the Hospital: The Right to Remain Silent in Civil Commitment*, 142 Am. J. Psychiatry 1074 (1985) (warning patients that anything they say may be used against them in the commitment hearing has little impact on their willingness to talk to staff or to cooperate with treatment).

11. > An explanation of rights as required by statute is obviously related to, but not perfectly congruent with, a complete explanation of the nature and consequences of the proceedings, past, present, and future, in which the respondent may be involved. Many of the individuals to whom we spoke in Columbus expressed the opinion that respondents often are not adequately informed about the entire involuntary civil commitment process, notwithstanding the many attempts to inform them of their legal rights. Respondents' attorneys report that many of their clients do not truly understand what is happening to them, what is going to happen to them in the future, and how they can go about getting various types of assistance. By all indications, those individuals who come into contact with respondents, in concert, make a sincere and diligent attempt to provide such explanation. Some suggest that sufficient comprehension may be beyond the capacities of many respondents.

Keilitz & Roach, *A Study of Defense Counsel and the Involuntary Civil Commitment System in Columbus, Ohio*, 13 Cap. U.L. Rev. 173, 185 n. 32 (1983).

12. *Cf.* Conn. Gen. Stat. Ann. § 17-183(c) (Supp. 1985) (patient to be informed of his or her rights "promptly"); Ill. Ann. Stat. ch. 91 1/2, § 2-200 (Smith-Hurd Supp. 1985) (immediately after admission, or "as soon thereafter as the condition of the recipient permits"); Md. Health-Gen. Code Ann. § 10-631(b)(1) (Supp. 1984) (within twelve hours of initial confinement); N.M. Stat. Ann. § 43-1-10(E) (1985) ("upon arrival," with no exceptions). *See generally* American Hospital Association, *A Patient's Bill of Rights, reprinted* in K. Countryman & A. Gekas, *Development and Implementation of a Patient's Bill of Rights in Hospitals* (1980).

13. *See* Guideline C3, "Explanations Made to the Respondent" (providing for explanations made to respondents by law enforcement officers at the time of custody-taking).

14. *See* Stromberg & Stone, *supra* note 3 ("Harm could result from administering a long description of legal rights to an agitated, frightened patient who, for the next few hours, needs a different kind of therapeutic interaction.").

15. A member of the National Task Force recounted an incident where a respondent was read an explanation of rights while he was in full leather restraints and was intermittently screaming loudly at hospital staff. Reportedly, hospital staff gave the impression that reading rights to the respondent in his agitated state was nothing short of a meaningless exercise. However, three days later, while conferring with his attorney, the respondent referred to his right to request a trial by jury, one of the rights explained to him during his agitated state. *But see* Cassileth, Zupkis, Sutton-Smith, & March, *supra* note 2 (noting that patients will not remember much of what they are told about treatment).

16. Wis. Stat. Ann. § 51.15(9) (West Supp. 1985); Ill. Ann. Stat. ch. 91 1/2, § 3-208 (Smith-Hurd Supp. 1985); *see also* I. Keilitz, *supra* note 8, at appendix A 25 (form informing patients of their rights on detention, including the right "to remain silent as anything you might say may be used as a basis for commitment"). *See generally* Miller, Maier, & Kaye, *supra* note 10.

17. *See* Miller, Maier, & Kaye, *supra* note 10.

D4. Prehearing Examination Procedures

Although state laws may allow mental health examinations of respondents to be deferred until immediately before a judicial hearing, a thorough and comprehensive examination should be initiated as promptly as possible upon the presentation of a person to a mental health facility for prehearing mental health examination.

Mental health examinations should conform to accepted professional standards. They should include the following elements:

(a) a social and mental health history of the respondent;

(b) a standard mental status examination, based upon a personal interview with respondent;

(c) diagnosis, prognosis, and the formulation of a plan of treatment and care for the respondent in the most appropriate setting; and

(d) an assessment of the factual and judgmental bases upon which determination can be made of whether the respondent meets the statutory criteria for involuntary civil commitment.

Commentary

Statutory requirements for mental health examinations reflect several related legislative intents that may or may not be expressly articulated in statutes. One purpose of mental health examinations is to test the allegations in petitions, affidavits, and applications for involuntary commitment completed by family members, acquaintances of the individual, law enforcement officers, mental health personnel, and others. The examination thus provides a check against inappropriate commitments. Another purpose is to determine, from the perspective of mental health professionals, whether a respondent should be involuntarily hospitalized or whether his or her needs can be best met by treatment and care other than compulsory hospitalization. Of course, the respondent may not require any mental health services. A third purpose of mental health examinations prior to judicial hearings is to provide a basis for a treatment plan and for

well-informed judicial decisions concerning compulsory treatment and care. Though not expressly articulated in statutes, still another purpose of the examination — and probably one that is most obvious and compelling to mental health professionals — is to determine what immediate steps should be taken to stabilize the condition of the respondent.[1]

Guideline D4 provides that professionally acceptable examinations should be performed as soon as possible after the respondent is presented to the facility for prehearing examination. The exigencies of emergency services provided to agitated or unstable respondents may require that the completion of a "thorough and comprehensive" examination be deferred until the respondent is settled. The guideline requires, however, that the respondent be attended to immediately and that the examination be promptly initiated, and it recommends that the examination be completed within a reasonable time.[2] Under no circumstances should the examination be delayed until immediately before the judicial hearing. Such delay would undermine the purposes of the prehearing examination and detract from its usefulness. In the worst situation, the examination is conducted immediately preceding the court hearing, making it virtually indistinguishable from the court hearing.[3]

The required elements of mental health examinations vary considerably from state to state. Some statutes describe, albeit in general terms, what an examination must include. For example, California requires a multidisciplinary professional analysis of the respondent's medical, psychological, educational, social, financial, and legal conditions as they may appear to constitute problems.[4] Texas requires the biographical data, a diagnosis, an opinion concerning the need for treatment and the likelihood of injury to self or others, and a description of the length and type of treatment recommended by the examiner.[5] Other statutes do not specify the elements of an adequate examination, but may prescribe a written form or certificate to be submitted to the court, from which the required elements of a mental health examination, the physician's findings, and the supporting facts must be in writing and must be transmitted to the clerk of the court by reliable and expeditious means.

Guideline D4 specifies the elements required of an adequate examination and provides that its conduct conform to professional standards. Examiners should allot adequate time for an examination. Although no standard time requirement for each element of the examination and no requirement that the examination be completed in one sitting are specified in the guideline, professionally accepted norms should guide examiners in individual cases. It seems highly unlikely, for example, that an acceptable examination can be accomplished in less than thirty minutes.[6]

Other aspects of an adequate examination are also dictated by professional standards, if not by common sense. For example, examinations should be conducted in a suitable environment.[7] All persons, except those present with the permission of the respondent, should be excluded from the examination room.[8]

Most states require at least two prehearing mental health examinations, the first shortly after or at the time of detention and admission to a mental health facility and the other a few days later. In Illinois, for example, two examinations are required to detain a person in a mental health facility and to bring the commitment issue to a formal judicial hearing. Illinois statute requires that the first examination take place at or before the time that a petition is prepared and a respondent is taken into custody.[9] An examination by a psychiatrist (whether it is the first or second examination) must be performed within twenty-four hours of the time that a person is admitted to a mental health facility. In practice, persons almost always receive both examinations within a twenty-four-hour period following their admission to a mental health facility; no one is held for a period of time greater than twenty-four hours without at least one examination.

Notes

1. *See* Guideline D6, "Prehearing Mental Health Treatment."

2. Statutes typically use three frameworks for specifying the timing of mental health examinations, which may or may not be linked to the purposes of the examinations: (1) a restriction on the time before a person must be examined after the occurrence of some important event in the commitment proceedings (e.g., the issuance of a court order or, more commonly, hospital admission), (2) a restriction on the timing for the appointment of an examiner (with the timing of the mental health examination *per se* not necessarily specified), and (3) a restriction on the time between mental health examination and judicial hearing.

3. *See* Supreme Court Study Commission on the Mentally Disabled & the Courts, *Civil Commitment in Minnesota*, Recommendation 2 and Comments, at 62-63 (Final Report July 20, 1979) (hereinafter cited as Commission) (some examinations were made prior to the day of the hearing and in one county "were difficult to distinguish from the hearing itself."). The Commission recommends that the examination be conducted two to seven days prior to the scheduled hearing. *Id.* at 63 (Recommendation 3).

4. Cal. Welf. & Inst. Code § 5008 (West 1984).

5. Tex. Rev. Civ. Stat. Ann. art. 5547-33 (Vernon Supp. 1986).

6. *See* Commission, *supra* note 3, at 63.

7. *See id.* at 62 (examinations should be conducted in a "professionally acceptable environment").

8. The Commission recommended that the respondent's counsel and, with the respondent's consent, other persons should be permitted to observe for "purposes of professional training." *Id.* at 62.

9. A valid petition filed by friends or relatives of the respondent prior to involuntary commitment must be accompanied by a "certificate executed by a physician, qualified examiner, or clinical psychologist" who must have examined the respondent less than seventy-two hours before admission to a hospital. Ill. Ann. Stat. ch. 91 1/2, § 3-602 (Smith-Hurd Supp. 1985). Within twenty-four hours, the respondent is subjected to a comprehensive physical and mental examination. *Id.* §§ 3-604, 3-607, 3-704. *See also* Van Duizend & Zimmerman, *The Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, 33 De Paul L. Rev. 225, 231-33 (1984).

D5. Prehearing Examination Reports

Promptly upon completing a prehearing mental health examination, the examiner should prepare a complete, written report of the results of the examination. Examiners should complete their examinations and submit written reports sufficiently in advance of judicial reviews to allow adequate time for consideration of the examination results.

Written reports should contain

(a) the identity of the examiner, the examiner's qualifications, the identity of the respondent, and the approximate time and location of the prehearing examination;

(b) a brief description of the procedures, techniques, and factual basis of the examiner's findings and opinions;

(c) a diagnosis of the person's mental health problems, including a description of the factual basis of the diagnosis (e.g., instances of grossly disturbed behavior, faulty perceptions, verbal threats, or overt acts);

(d) the prognosis, i.e., the probable course of the mental health disorder with and without immediate treatment and care, if this can be specified; and

(e) a preliminary treatment plan or, at a minimum, recommendations for treatment and care and prognosis for the person's improvement if recommendations are followed.

Commentary

Guideline D5 provides the requirements for written reports of prehearing examinations and specifies the five elements to be included in each report. As a matter of convenience and in order to facilitate reporting, the use of a standard format is recommended. The standard format should be of sufficient length and depth to allow an accurate account of all the items required by Guideline D5. The standard report format should guide the examiner in preparing an accurate and useful report. It should not be a checklist whereby examination results are associated with predetermined categories that do not accommodate individual differences.[1]

Paragraph (e) requires the filing of a preliminary treatment plan.[2] Ideally, a preliminary plan specifies (a) the proposed treatment goals, (b) the services and treatment methods available to assist in meeting those goals, (c) the services and treatment methods most likely to assist the respondent, (d) the proposed treatment setting and reasonable alternatives, and (e) an estimate of the time required to achieve the treatment goals. The plan should be tailored to the respondent's needs and be submitted with the examination report. It should clarify for the court, the respondent, and the service providers what the preliminary treatment objectives are, how the objectives will be achieved, and how long treatment may be required.

Because only a brief time is available for preparing the plan, it should contain only the most essential information. More detailed information regarding treatment goals, proposed services, and proposed treatment settings (e.g., a public hospital, private facility, or community mental health center), and the basis for the recommendations, may be presented at the dispositional portion of the commitment hearing. Except for the description of the available services, however, "boilerplate" language should not be used. This prohibition emphasizes the consensus that a truly individualized plan is required and that standardized language should not be accepted.

Guideline D5 does not require the examiner to report an opinion on the ultimate legal issue of whether the respondent meets the criteria for involuntary civil commitment, though the examiner may be required as a matter of law to decide whether a respondent should be hospitalized and treated pending the outcome of a judicial hearing or released immediately after the examination.[3] Although decisions about the "committability" of respondents presented for prehearing examination are made as a matter of practice throughout the country — and should be made as early as possible in accordance with the "least restrictive alternative"[4] doctrine — this legal determination is inappropriate in an examiner's report. Without a factual basis for the legal determination as provided in paragraph (b), such conclusory opinions by prehearing examiners are of little use to the trier of fact in a judicial hearing. Moreover, when the factual basis for the opinion is provided, the conclusory opinion of the examiner regarding whether the respondent meets the legal criteria for involuntary civil commitment is superfluous.[5]

Notes

1. The standardized form for prehearing examination reports used in Minnesota is an example of a form that provides for detailed information about individual cases without imposing an onerous reporting task on the examiner. Slattengren, *Proposed Civil Commitment Forms, in Civil Commitment in Minnesota* 73, 106 (Advanced Legal Education, Hamline University School of Law, 1985) (Prehearing Examination Report).

2. Of the states requiring treatment personnel to submit an individualized treatment plan to the court, most indicate that preparation of the full plan should follow the commitment hearing. *See, e.g.*, Ind. Code Ann. § 16-14-9.1-9 (Burns Supp. 1985); Mich. Comp. Laws Ann. §§ 330.1468 -.1473 (West 1980 & Supp. 1985); N.M. Stat. Ann. § 43-1-9 (1984). A few states, however, specify that a preliminary or proposed plan be submitted in time for the court to consider it at the hearing. *See, e.g.*, Ill Ann. Stat. ch. 91 1/2, § 3-810 (Smith-Hurd Supp. 1985); N.C. Gen. Stat. § 122C-263 (Supp. 1985).

3. *Cf.* Ill. Ann. Stat. ch. 91 1/2, §§ 3-604, 3-607, 3-704 (Smith-Hurd Supp. 1985); Cal. Welf. & Inst. Code § 5206 (West 1984); Mo. Ann. Stat. § 632.300 (Vernon Supp. 1986); Wis. Stat. Ann. § 51.15(4)(b) (West Supp. 1985); Va. Code § 37.1-70 (1984).

4. *See* Commentary, Guideline G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment."

5. Although National Task Force members agreed that prehearing examinations should be completed and their results made available to both parties as soon as possible, they disagreed about the court's access to the report before the judicial hearing. The majority favored limiting the court's access to the prehearing examination report so as not to prejudice the court before the parties had the opportunity to present their evidence. The extreme position of the majority's recommendation to limit the court's access to the examiner's report would make the report available only at the dispositional phase of the judicial hearing, and not before. Two members of the National Task Force argued that limiting the court's access to the examiner's report flies in the face of reality. Only in an ideal adversarial system, they argued, can the trier of fact in involuntary civil commitment proceedings rely upon the parties to present an adequate factual basis for an "adjudication" of committability. In the absence of complete and accurate representations by the opposing parties regarding the question of whether the respondent is a fit subject for involuntary civil commitment, the examiner's report fills a gap in the knowledge necessary to make a proper judicial determination. *Cf.* American Bar Association, *Standards for Criminal Justice*, standard 7-3.8 (2d ed. 1980) (providing the standard for discovery of written reports concerning a *criminal* defendant's present mental competency to stand trial and mental condition at the time of the crime).

D6. Prehearing Mental Health Treatment

Mental health facilities to which respondents are presented for prehearing mental health examinations have an obligation to provide necessary mental health services and should not be operated as mere "holding facilities" for respondents awaiting judicial hearings.

Respondents undergoing prehearing examination should be given appropriate mental health and related social services on a short-term basis, but only with their consent or in emergency situations.

Commentary

As one commentator has stated, "the best remedy for reducing wholesale involuntary confinement is good treatment in a decent local facility where the staff acknowledges and respects the legal rights of the patients."[1] Conflicting interests, however, are at stake in regard to the issue of the mental health treatment and care provided to respondents before full judicial review. On the one hand, when a respondent is first presented to a mental health facility, judicial review has not yet determined that the respondent indeed meets the criteria for involuntary civil commitment. A respondent may, in fact, have been improperly detained, although this possibility would be minimized by appropriate screening procedures in accord with the guidelines in Part B. On the other hand, a respondent's deteriorating mental condition and aberrant behavior may seriously threaten not only his or her own safety but also that of others in the mental health facility. In addition, although not often openly acknowledged, factors of economy, efficiency, and administrative convenience may also be at work in decision-making about prehearing treatment and care.

Guideline D6 encourages prompt and appropriate treatment and care for consenting respondents. Given a respondent's informed consent and given due consideration of whether prehearing treatment will adversely affect a respondent's appearance and demeanor during judicial hearings, no compelling reasons exist for withholding needed mental health care and treatment during the prehearing period.[2]

Although a few statutes distinguish the treatment and care that should be provided to respondents awaiting commitment hearings from the treatment and care that should be provided to respondents already judicially committed,[3] mental health professionals are often reluctant to treat persons before adjudication of commitment because of a fear of liability. They may prescribe therapy, but refuse to provide medication.[4] Unless a respondent exercises his or her right to refuse treatment or care, which should be respected in all cases not presenting clear and legitimate emergencies, the reluctance of qualified mental health professionals to provide needed care and treatment is contrary to the interests of the person, the state, and society in general, especially in view of the already strained resources of the mental health service delivery system.

Guideline D6 expresses a preference for voluntary mental health treatment. It imposes upon mental health facilities the obligation to provide respondents with needed treatment and care which the respondent has not refused. The guideline does not address the problem presented in cases in which the respondent cannot give his or her informed consent to needed treatment and care and which do not constitute emergency situations. How many of these difficult cases exist is not known, but the actual number is likely to be very small. Most involuntary patients accept care and treatment. Only one out of ten refuses treatment, usually the administration of psychotropic drugs.[5] In the absence of informed consent, prehearing treatment and care should not be provided to respondents except in emergency situations.[6]

Without minimizing the burdens and strains that violent, abusive, and uncooperative patients impose on the staffs and resources of mental health facilities,[7] the focus of Guideline D6 is squarely on the great majority of patients who consent to treatment. The policies and procedures for delivering mental health services to this majority should not be influenced unduly by the small group of respondents who refuse treatment and the even smaller group of patients who cannot give their consent and for whom court review and substitute consent may be indicated.

It is important to stress the role of the attorney in the treatment and care provided to the respondent pending court review of commitment. The attorney can assist the respondent not only in deciding whether to refuse a particular type of treatment but also in communicating to the treatment providers the respondent's preferences for particular types of treatment.8 Indeed, the attorney

may well advise a reluctant respondent to consent to treatment in the hope that it will lead to a remission which will avert the need for commitment.

Notes

1. A. Stone, *Mental Health and Law: A System in Transition*, 42 (1976)(emphasis omitted).

2. Disagreement exists over whether respondents ought to be medicated at the time of a court hearing. On the one hand, a respondent who is medicated will frequently make a better appearance before the hearing officer, because he or she is under greater control and will not display gross symptoms of psychosis that may influence the decision to commit. On the other hand, medication or overmedication can work against a respondent during a court hearing. Medication sometimes will cloud a respondent's thinking, rather than sharpen it, and diminish the respondent's ability to testify effectively on his or her own behalf. Undesirable side effects of some medications also may give some individuals the appearance of being mentally ill, which works against them during a court hearing. If any medication is administered to a respondent during the prehearing period, and if the respondent's treating physician has any reason to believe that the respondent's behavior in court will be affected by the medication, the physician should inform the respondent's attorney, and the attorney representing the hospital or state, what medications were administered and what effects these medications are likely to have on the respondent's behavior during a court hearing as well as on the respondent's ability to assist the attorney.

3. Only a few statutes specifically address issues of prehearing treatment. For example, except for especially intrusive treatments (e.g., psychosurgery and convulsive treatments), California's Lanterman-Petris-Short Act fails to address the issue of the nature and type of treatment to be provided during a seventy-two-hour emergency "hold." Cal. Welf. & Inst. Code § 5152 (West Supp. 1986). Louisiana law permits respondents to receive medication and treatment without their consent, although no major surgical procedure or electroshock therapy may be performed without the written consent of a court. La. Rev. Stat. Ann. § 28.53 (West Supp. 1986). The North Carolina statute provides that, pending the court hearing, a qualified physician attending the person is authorized to administer to the person "reasonable and appropriate medication and treatment that is consistent with accepted medical standards." N.C. Gen. Stat. § 122C-266(d) (Supp. 1985). Illinois law allows hospitals to treat respondents as soon as a first examination and commitment certificates have been completed. Ill. Ann. Stat. ch. 91 1/2, § 3-608 (Smith-Hurd Supp. 1985). In practice, psychotropic medication is frequently given at this point in time. *See* J. Zimmerman, *Involuntary Civil Commitment in Chicago* 48 (1982). Wisconsin's Mental Health Act defines treatment as "those psychological, educational, social, chemical, medical or somatic techniques designed to bring about rehabilitation of a mentally ill, alcoholic, drug dependent, or developmentally disabled person." Wis. Stat. Ann. §51.01(17) (West Supp. 1985). Respondents detained pending probable cause or final commitment hearings have the right to refuse all treatment except when treatment is ordered by the court after a judicial hearing and a determination of the respondent's incompetency to make treatment decisions or when medication or treatment is necessary to prevent serious physical harm to the respondent or to others. *Id.* §§ 51.15(8), 51.61(g), (h). A respondent may consent to treatment, but only after he or she has been informed of the right to refuse treatment and has signed a written consent to such treatment. *Id*. §51.20(8)(c).

A recent report of practices in Milwaukee indicated that respondents awaiting judicial hearing received little treatment "designed to bring about rehabilitation," except for the administration of psychotropic medication upon the respondent's voluntary consent. I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 60 (1983). Respondents were only infrequently given medication without informed consent. Judicial hearings to determine competency to refuse medication in court orders permitting medication to be administered without consent were rare. *Id.* Generally, state statutes allow mental health and medical treatment of persons before commitment hearings, but with qualifications (e.g., in a person's "best interest"), with restrictions (e.g., time limits on treatments), and with exceptions (e.g., subject to consent, protection of civil rights).

4. For example, one psychiatrist in Ohio reported that hospital staff sometimes seemed preoccupied with liability issues, to the detriment of their best clinical judgments. This preoccupation caused staff to be overly cautious and practice what has been referred to as "defensive psychiatry." I. Keilitz, *Involuntary Civil Commitment in Columbus, Ohio* 46 (1982). A study in Arizona revealed that although the treatment available during detention varied in different counties, generally involuntary patients received "little psychiatric treatment other than medication and physical removal from [their] normal environment." D. Wexler, *Mental Health Law: Major Issues* 80 (1981).

5. I. Keilitz & B. McGraw, *supra* note 3, at 63. This estimate is consistent with at least one study, which found that less than ten percent of hospitalized patients refused medication in a manner that interfered with treatment. Appelbaum & Gutheil, *Drug Refusal: A Study of Psychiatric Inpatients*, 137 Am. J. Psychiatry 340 (1980).

6. Recognizing that courts throughout the country continue to debate the definition and scope of the term "emergency," the National Task Force did not attempt to define the term, but pointed with approval to the American Psychiatric Association's definition of the phrase "emergency situation."

> [A] situation in which the patient exhibits substantial behavior that is self-destructive or assaultive, threatens significant damage to the property of others, or indicates that the patient is suffering extreme anxiety amounting to panic, or sudden exacerbation of his severe mental disorder.

American Psychiatric Association, *Guidelines for Legislation on the Psychiatric Hospitalization of Adults in Issues in Forensic Psychiatry* 27, 35 (1984). *See also* Stromberg & Stone, *A Model State Law of Civil Commitment of the Mentally Ill*, 20 Harvard J. on Legis. 275, 294-95 (1983); Wexler, *APA's Model Law: A Commitment Code by and for Psychiatrists*, 36 Hosp. and Community Psychiatry 281, 283 (1985).

7. [C]onsider the effect of the frustration of the treatment process on the mental health professional. The background of the nurse, the social worker, the psychologist and psychiatrist is one of training and experience in helping, curing as far as possible, and relieving anxiety and suffering. In a setting where treatment is forbidden, these staff are reduced instead to controlling behavior, often through the use of physical restraint or force. When faced with this additional level of physical violence and psychological tension they become more preoccupied with their own safety and tend to become defensive toward patients rather than open and empathetic, supportive, and healing. Staff burnout in such emergency care situations is always higher than in areas without these stresses and burnout is exaggerated needlessly by the prolonged period of waiting for treatment to begin.

R. Gerhardstein, remarks at the Annual Meeting of the Alliance for the Mentally Ill of Wisconsin (September 25, 1982), *quoted in* I. Keilitz & B. McGraw, *supra* note 3, at 61. *See also* White & White, *Involuntary Committed Patients' Constitutional Right to Refuse Treatment: A Challenge to Psychology*, 36 Am. Psychologist 953, 959 (1981) ("It is inconceivable that great numbers of committed individuals or their guardians will refuse legitimate psychological assistance with the problems that caused the individual to be confined.").

> [W]e found that *20%* of our refusing sample refused treatment in a way that seriously impaired their own treatment (one of this group committed suicide shortly after the study) and that the disruptive effect on the milieu caused by this group significantly interfered with the treatment of *other* patients, as well as with the right of those other patients to a safe, orderly, and therapeutic environment — a right that is all too often scanted in discussion of RTRT [right to refuse treatment].

Gutheil, *More on the Right to Refuse Treatment*, 37 Am. Psychologist 974, 974 (1982).

8. *See* Fransway & Messinger, *Prehearing Matters*, in *Civil*

Commitment in Minnesota, at 53, Respondent's Counsels — checklist and forms (Advanced Legal Education, Hamline University School of Law, 1985). This manual contains a client summary sheet which instructs attorneys to ask respondents about previous hospitalizations and treatment providers, whether any of the previous treatment and care were helpful, and whether the respondent is taking medications and to inquire into other related matters relevant to the type and level of care provided to the respondent before any court review takes place. *But see* Appelbaum, *The Rising Tide of Patients' Rights Advocacy*, 37 Hosp. & Community Psychiatry 9 (1986) (noting that "serious thought must be given to the effects of an increasing number of patients' rights advocates in the mental health arena").

D7. Negotiated Settlements of Cases

Involuntary civil commitment cases represent disputes among a number of parties — the respondent, the state, and the petitioner — over therapeutic and protective measures undertaken on behalf of the respondent and society. Whenever possible, those disputes should be resolved informally to the satisfaction of all parties, thereby avoiding a formal commitment process.

(a) As soon as possible after involuntary civil commitment proceedings have been initiated (*viz*., a commitment petition has been filed with a court or a person has been taken into custody and involuntarily detained) and before a formal commitment hearing, the respondent, through his or her attorney, and the attorney for the state should attempt to negotiate an agreement and a satisfactory settlement of the commitment case.

(b) To ensure that the interests of all parties are well represented in the negotiation, the attorney for the respondent should confer with appropriate persons, such as the respondent, the petitioner, the mental health screening officer, mental health practitioners, and social service providers who have dealt with the respondent in the past (or who will provide care to the respondent in the future if the proposed settlement of the case is agreed to), before reaching an agreement.

(c) The terms of the negotiated agreement should be presented to the court for review.

Commentary

Commitment proceedings need not take the statutorily prescribed course toward compulsory hospitalization preceded by temporary detention and judicial hearing. Guideline D7 encourages diversion from this course by means of negotiation and appropriate, suitable settlement of commitment cases before a hearing. In most cases, negotiated settlements not only are acceptable to all parties but also obviate time-consuming and costly formal proceedings.[1]

Negotiations should be entered into with the concurrence of the respondent. When a respondent is incapable of concurrence, his or her attorney should be authorized to negotiate a settlement of the commitment case with the attorney for the state, based on the belief that the negotiated settlement is in the best interest of his or her client (see Guideline E5, "Prehearing Duties of Respondents' Attorneys").

In Milwaukee, negotiated settlements take two forms: (a) "court-ordered voluntary" agreements, which result in voluntary inpatient status of the respondent, and (b) stipulated settlements, which lead to outpatient treatment and care.[2] A negotiated settlement is the result of a relatively unstructured process of conferences and negotiations between the attorney representing the respondent and the corporation counsel, who represents the state. The process typically occurs prior to a probable cause hearing but may often follow it. The parties negotiate, reach an agreement, and then seek postponement of the probable cause hearing or final commitment hearing for a specified period of time during which the respondent participates in the agreed-upon program of treatment and care. Unless the respondent fails to comply with the terms of the agreement, the case is dismissed at the end of the treatment period. However, if the respondent has failed to comply, the attorney for the state typically requests that the case be reopened.

In Milwaukee, the elements of a proposed settlement are initially formulated by the respondent's attorney. In developing a settlement proposal, the attorney typically interviews the respondent the evening before the scheduled probable cause hearing and consults with hospital staff, other mental health professionals, and, although less frequently, family members and petitioners. Although the attorney for the state may investigate alternative arrangements before the respondent's attorney presents a proposed settlement, the attorney for the state typically waits for the respondent's counsel to present the settlement proposal. Once the settlement proposal is presented, the attorney for the state may consult with hospital staff and with members of the respondent's family. The attorney for the state then accepts the proposal as presented, negotiates modifications of the conditions of the proposed settlement, or rejects the proposal outright and proceeds to a probable cause hearing.[3]

A stipulated settlement may result in the case being held open for up to ninety days. Conditions of stipulated settlements may include the administration of psychotropic medication on an outpatient basis, psychotherapy, vocational rehabilitation, day care, placement in a group home or board-and-care facility, the provision of food stamps or "meals on wheels," homemakers' services, and other social services. At the time of the originally scheduled probable cause hearing, the parties present the stipulated settlement to the court, which usually adopts it as the order of the court.

Although some courts may choose to supervise and

review the settlement more closely than others,[4] the guideline recommends that they at least be given the opportunity for review. Court involvement in the settlement process is important to ensure thoughtful settlements and to protect the interests of the participants and the community.[5]

Although the process of negotiation and settlement of commitment cases prior to judicial hearing can be faulted,[6] it can lead to an appropriate application of the "least restrictive alternative" doctrine by screening and diverting appropriate cases from compulsory hospitalization, if the process is conducted diligently and conscientiously. The process can channel the energies of attorneys, judges, and mental health personnel (otherwise devoted to litigious confrontation in the courts) to finding, investigating, and exploring appropriate mental health care and treatment alternatives. At the very least, the process is consistent with a national trend toward conciliation rather than litigious confrontation in involuntary civil commitment proceedings by emphasizing the expeditious provision of needed treatment and care.[7]

Notes

1. *See* Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 Calif. L. Rev. 816, 825-26 (1974) ("The importance of negotiated settlements cannot be overestimated. . . . Indeed, it seems likely that many patients who are discharged through the negotiating process would have remained hospitalized if their cases had come before a court."); Lewis, Goetz, Schoenfield, Gordon, & Griffin, *The Negotiation of Involuntary Civil Commitment*, 18 L. & Soc'y 629 (1984); Gilboy & Schmidt, *Voluntary Hospitalization of the Mentally Ill*, 66 Nw. U.L. Rev. 429 (1971).

2. I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 72 (1983).

3. *Id.* at 73.

4. One member of the National Task Force, a judge who regularly hears commitment cases, indicated that he refuses even to consider a "plea bargain" by the attorneys unless he has had the opportunity to hear and consider the opinions of knowledgeable mental health professionals regarding the proposed settlement. He noted that the attorneys are often "more concerned with rights than with needs."

5. Depending on the particular mechanism of court review or approval of the settlement or negotiated agreement (e.g., formal court order incorporating the terms or conditions of the settlement), court review or approval may relieve the parties of some liability for actions taken as part of the settlement process in some jurisdictions. Although the National Task Force acknowledged the potential importance of the issue of liability arising from a settlement or a negotiated agreement of commitment cases, it did not take a position on the issue. *See generally* S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* 213-15 (3rd. ed. 1985); *see also* ch. 10, Provider-Patient Relations: Confidentiality and Liability, *id.*

6. Critics of the negotiation and settlement process in Milwaukee County argued that the process tips the balance in involuntary civil commitment proceedings too much in favor of the respondent's autonomy and liberty interests, that it compromises much-needed treatment and care, that it ignores the community's interests in protection, that it does not adequately take into account the interests of the respondent's family, and, finally, that it is nothing but a "ruse perpetrated by attorneys of the two public defender programs in Milwaukee, a ruse to which corporation counsel is a willing accomplice." I. Keilitz & B. McGraw, supra note 2, at 75. Another criticism leveled at the negotiated settlement process in Milwaukee County is that the monitoring of a respondent's compliance with the terms and conditions of the negotiated settlement is inadequate. *See also* Lewis, Goetz, Schoenfield, Gordon, & Griffin, *supra* note 1.

7. *See* Keilitz & Van Duizend, *Current Trends in the Involuntary Civil Commitment of Mentally Disabled Persons*, 31 Rehab. Psychology 27 (1986).

D8. Prehearing Disposition

If prehearing examination reveals that the respondent does not meet the legal criteria for involuntary commitment, he or she should promptly be released from detention. The person should not, however, be left without access to mental health care and related social services.

(a) A person presented to an inpatient mental health facility for prehearing examination or involuntarily admitted for short-term treatment and care should be discharged or converted to voluntary patient status, if the person so desires, if he or she no longer meets the legal commitment criteria. Court review of the release decision, if required by statute, should be expedited to avoid unnecessarily prolonged hospitalization. If the person requires voluntary mental health care, medical treatment, or related social services that cannot be provided by the facility, the facility staff should refer the person to an appropriate source of assistance.

(b) If the determination to release from involuntary care is made prior to the hearing on the petition for involuntary civil commitment, the facility should immediately inform the mental health screening officer of the person's release, his or her current condition, his or her need for further treatment or services, and whether he or she has been referred to another facility or program.

(c) A mental health screening officer who has received notice of a respondent's release should in turn notify the court, members of the person's family who may have petitioned for the person's involuntary treatment, and the attorneys for the respondent and state.

Commentary

Guideline D8 makes it clear that persons who do not require involuntary treatment or who, after a brief period of hospitalization, have improved to the extent that they no longer meet the legal criteria for involuntary hospitalization do not have to wait for a judicial hearing to be released from involuntary care. Most states currently permit care and treatment facilities to discharge a person before a judicial hearing if the professional in charge of the person's care believes that compulsory treatment

or habilitative services in a custodial setting are not necessary.[1]

Importantly, this guideline recognizes the necessity of providing access to voluntary mental health care to persons who have been diverted from involuntary civil commitment. It is reasonable to presume that many, if not most, of the respondents who are presented for prehearing examination are in need of some type of mental health treatment or related social services, if not involuntary care. This may be especially true if adequate prehearing screening has taken place.

Guideline D8 provides that in those states where a prehearing examiner does not have unilateral authority to release a respondent before a court hearing, even if the examiner believes that the respondent is no longer a fit subject for involuntary hospitalization, court review should be expedited so as to minimize unnecessary confinement of the person and to avoid the costs of unnecessary hospitalization. The mechanisms for such expedited court review are not specified, but they may include (a) an ex parte hearing scheduled shortly after the mental health professional's determination that the respondent no longer meets the legal criteria for involuntary hospitalization, (b) moving up the time of a probable cause hearing or a full evidentiary hearing mandated by law, and (c) a court's dismissal of a pending petition or emergency application by letter following a review of a prehearing examiner's report.[2]

Although Guideline D8 assumes a preference for voluntary treatment, release, and diversion before judicial hearing, it does not suggest that the types of checks and balances applied by courts in reaching decisions to release respondents following court review should be ignored during the prehearing period. The interests of family members, who may have petitioned the court for the involuntary treatment of the respondent, in particular, should be protected in the determination to release.[3]

Although the appropriateness of immediate release of a respondent when detention is no longer warranted may seem self-evident, it often does not take place because of the fear of liability or a feeling that persons are entitled to their day in court. Respondents who are presented for prehearing examination in some jurisdictions have, as a matter of course, remained hospitalized involuntarily until the judicial hearing on the commitment petition, even though the examiner or treatment provider has determined that the person does not meet the criteria for commitment.[4] When this practice occurs despite the legal authority for immediate release, a community coordinating council (see Guideline A1) or similar body should take actions to ensure that appropriate discretion to release a respondent is exercised as provided by Guideline D8 and as authorized by law.

Fear of liability for unpredictable violence by a released or diverted involuntary patient, which may cause treatment providers to be improperly conservative in their release decisions, may be calmed by education and training regarding the legal and practical parameters of liability for wrongful discharge. National Task Force members agreed that the extremes of total immunity from liability, on the one hand, and absolute accountability for release decisions, on the other hand, should be avoided. Generally speaking, a qualified immunity from liability (viz., immunity for good-faith actions in the absence of gross negligence or reckless disregard of the facts) for release decisions was considered the best precautionary legal measure for appropriate release decisions.

Paragraphs (b) and (c) urge that the hospital or other treatment and care facility advise the mental health screening officer involved in the respondent's admission if the respondent is being released, and they provide that the officer notify the court, parties that may have sought the respondent's treatment and care, and the attorneys representing the state and the respondent. This notification requirement fulfills four purposes. The first is common courtesy to all concerned. The second is to help the person obtain needed services in the community. All too often, the link between an admitting hospital and community-based programs is absent.[5] Contacting the persons most responsible for initiating and overseeing the involuntary civil commitment process and informing them of the respondent's release and ongoing needs should help to reinforce the guidelines for screening in Part B. The third purpose is to protect against the release of persons who require continued compulsory hospitalization. Family members, in particular, are often frustrated by the inability to obtain help. The notification requirements will assist the mental health screening officer and family members to take action to protect the person and assure that necessary services are provided in an appropriate setting. Finally, the notice requirements can provide mental health screening officers, examining physicians, and others involved in the initial stages of the process with feedback about their screening decision, thereby helping to improve the entire involuntary civil commitment process.[6]

A two-step notification procedure is recommended in order to reduce the administrative burden on hospital staff and to facilitate the release of persons as soon as they are ready for discharge. Professionals responsible for the respondent's care and treatment need fill out only one form or make one telephone call to a mental health screening officer. Notifying the court, the petitioner, and the attorneys will not be alien to the mental health screening officer, who should be well-versed in the substantive and procedural legal requirements applicable and, in most instances, already will have spoken to and advised the petitioner.

Nothing in this guideline is intended to forestall the use of alternative procedures, such as conditioned release or expedited judicial hearings. When those alternatives are

used, however, notice procedures similar to those recommended in the guideline should be used.

Notes

1. Broad discretion is given to mental health personnel to make release and diversion decisions. *See generally*, S. Brakel, J. Parry, & B. Wiener, *The Mentally Disabled and the Law* 203-15 (3rd. ed. 1985). Discharge of a respondent typically occurs if the mental health professional in charge of the respondent's prehearing examination and short-term treatment and care believes that compulsory mental health care and treatment no longer are, or never were, necessary. Unless a respondent has been indicted or convicted of a crime, most states empower mental health personnel (e.g., admitting or attending physician, medical director, examiner, or facility director) to release or divert a respondent from compulsory hospitalization. Some states require the court's consent. *E.g*., Idaho Code § 66-329(d) (Supp. 1985); Iowa Code Ann. § 229.10(3) (West 1985); N.Y. Mental Hyg. Law § 9.31(c) & (d) (McKinney 1978 & Supp. 1986). Dismissal of the commitment proceedings and release of a respondent may also occur if procedural statutory requirements for judicial proceedings have not been met. California, West Virginia, and Texas, for example, require the immediate release of a respondent upon a failure to fulfill statutory requirements for mental health examination, mental health certification, filing of papers, or issuance of orders within required time limits. Cal. Welf. & Inst. Code § 5256.5 (West 1984); Tex. Rev. Civ. Stat. Ann. art. 5547-46(c) (Vernon Supp. 1986); W. Va. Code § 27-5.3 (1980). Other states require release when commitment criteria can no longer be met. *E.g*., Ind. Code Ann. § 16-14-9.1-7(d) (Burns Supp. 1985); Iowa Code Ann. §229. App. rule 2 (West 1985); N.C. Gen. Stat. § 122C-266(a)(3) (Supp. 1985); Ohio Rev. Code Ann. § 5122.10 (Page 1981); Ill. Ann. Stat. ch. 91 1/2, §§3-604, 3-610 (Smith-Hurd Supp. 1985). In Ohio, for example, if hospital staff fail to find a respondent both mentally ill and dangerous, the head of the hospital must release the respondent (this broad power to discharge a person extends even to after judicial hearing). Ohio Rev. Code Ann. §5122.10 (Page 1981). Unless the respondent has been indicted or convicted of a crime, the head of the hospital may discharge a respondent without court authorization or consent. *Id*. Some state statutes simply require release if no reasonable grounds exist for detaining a person or if release is appropriate. For example, it is estimated that almost one-half of all persons presented for emergency admission at Bellevue Hospital in New York City are screened and discharged following an admitting physician's examination. L. Fitch, B. McGraw, J. Hendryx, & T. Marvell, *Involuntary Civil Commitment in the First Judicial Department, New York City* 23 (1982).

In most states, a diversion and subsequent release prior to judicial hearing may be achieved if a respondent requests voluntary status and if the mental health facility or the court agrees to the conversion from involuntary status. The law in some states explicitly encourages conversion from involuntary to voluntary status. New York's Mental Hygiene Law, for example, states, "Nothing in this article shall be construed to prohibit any facility director from converting, and it shall be his duty to convert, the admission of any involuntary patients suitable and willing to apply therefore to a voluntary status." N.Y. Mental Hyg. Law § 9.23(a) (McKinney Supp. 1986). Most statutes give respondents only the right to apply for voluntary admission, not an automatic right to voluntary admission. A facility director may accept or deny the application for voluntary admission. In some states a facility director must accept a request for voluntary admission, but may detain the respondent for a period of time pending the filing of another petition. E.g. Ohio Rev. Code Ann. §§ 5122.10, 5122.02 (Page 1981 & Supp. 1984). In Illinois, even if the facility director accepts a respondent's application for voluntary admission, the statute allows the judge to consider whether such an admission will be in the best interests of the respondent and the public. Ill. Ann. Stat. ch. 91 1/2, §3-801 (Smith-Hurd Supp. 1985). Thus, a judge may deny a respondent's application for voluntary admission and may hear the case for involuntary commitment. This element of the Illinois statute makes it possible to prevent patients from "abusing" the voluntary application privilege by using it merely as a vehicle for obtaining release within a certain period of time.

Finally, some state statutes require that specified individuals receive notice of a respondent's release or diversion from compulsory hospitalization. In at least two states, the committing court and the mental health facility must have notice of a respondent's release. Iowa Code Ann. § 229.16 (West 1985); N.C. Gen. Stat. § 122C-266(a)(2) (Supp. 1985). A minority of states require that the head of the local social services or mental health department be notified of a respondent's release. *E.g*., N.Y. Mental Hyg. Law § 9.31(e) (McKinney 1978).

2. A strength of the Illinois system is that the involuntary commitment process may be halted quickly when such a commitment appears to be unnecessary or ill-considered. If either of the two required examiners does not find that the respondent meets the statutorily prescribed criteria, the respondent is immediately released and the case does not proceed to a judicial hearing. If the respondent's symptoms remit during the period of time preceding the judicial hearing, the hospital will discharge the patient. In this situation, if the case has already been set for a hearing, it will be dismissed when it is called. Similarly, if a respondent consents to a voluntary admission, counsel confirms that the decision is indeed voluntary, and the court concludes that such an admission is of benefit to the respondent and the public, the case is dismissed.

Van Duizend & Zimmerman, *Involuntary Civil Commitment in Chicago: Practices and Procedures*, 33 De Paul L. Rev. 225, 250 (1984).

> In Pima County [Arizona], a system has been informally devised to permit the immediate release of patients who have been medically determined not to be in need of hospitalization. On reaching such a diagnosis, the examining doctor asks a county psychiatric social worker to contact the court, to inform the court of the medical finding, and to request that the petition be immediately dismissed. The petititon is then dismissed, the patient is released, and a form letter is transmitted from the doctor to the court for insertion in the patient's legal file. Although the doctors in Pima County seek to have the petitioner acquiesce in the dismissal of the petition, the petitioner's consent is by no means considered a necessary prerequisite to the operation of their prehearing discharge procedure.
>
> In Maricopa County, there also exists a procedure for releasing patients prior to hearing who, in the opinion of the doctors, are not in need of hospitalization. But the procedure is more limited than in Pima County because, as learned in interviews with the judge and a testifying psychiatrist, a Maricopa County petition will not be dismissed without the petitioner's consent unless it is completely frivolous. Accordingly, a recalcitrant petitioner can block the prehearing dismissal of a Maricopa County commitment petition — thereby necessitating the continued custody of the patient on the county hospital psychiatric ward until the date of the hearing — even though both examining psychiatrists feel hospitalization is not in order. That impediment to release seems particularly curious in view of the fact that, at the commitment hearing, the doctors will no doubt testify against involuntary hospitalization, and the petition will invariably be dismissed at that time.

D. Wexler, *Mental Health and the Law* 003-04 (1981) (footnote omitted).

3. Whether explicitly or implicitly, in deciding whether to release a respondent, the courts generally apply a balancing test, weighing several competing interests, including (a) the private, individual interests, especially those of the respondent, that are affected by the respondent's release; (b) the public's interest in the treatment of the respondent in a secure, inpatient setting; (c) the related public interest in protecting society from the respondent's dangerous conduct; and (d) the court's interest in not imposing undue fiscal and administrative burdens on those mental health and social service agencies given the responsibility for implementing release or conditional release procedures. As the legal and mental health communities become less concerned with improper or unnecessarily protracted periods of compulsory hospitalization and

more concerned with improper or premature release of mentally ill persons from inpatient mental health care, the values placed on these competing interests may shift. Organizations have sprung up in some states advocating the interests of family members of respondents. Members of these groups are frustrated with the "revolving door" of many hospital facilities and the lack of community resources, and they have effectively advocated lengthy hospitalization and tighter requirements for release of respondents to communities that are unprepared to accept them.

> Many advocates for the mentally ill in Chicago feel that the major problem in the city is getting help for those who need it -- arranging for the mentally ill to get into the hospitals and keeping them there long enough for treatment to become effective. Staff at some of the community mental health centers [CMHC] are frustrated by the public hospitals' tendency to refuse voluntary admissions for people whom the CMHC staff refer there. Staff from one city clinic estimate that as many as 50 percent of the people whom they feel are appropriate for inpatient treatment and whom they refer to the public hospitals are denied admission.
>
> CMHC staff in some instances have begun extraordinary procedures to try to have their referrals admitted by the hospitals. CMHC doctors admit to "coaching" people on what to tell examiners at the hospitals to convince them that they are mentally ill enough to be admitted for treatment. Sometimes, the doctors at the CMHCs make personal telephone calls to examiners at the hospitals in an attempt to increase the person's likelihood of being accepted into treatment. As a backup measure, CMHC psychiatrists are filling out medical certificates to help family members quickly initiate involuntary proceedings in cases where the persons who need help are denied voluntary admission.

J. Zimmerman, *Involuntary Civil Commitment in Chicago* 112 (1982).

4. *See* Fitch, *Involuntary Commitment of the Mentally Disabled: Implementation of the Law in Winston-Salem, North Carolina*, 14 N.C. Cent. L.J. 406, 418 (1984).

5. L. Fitch, *Involuntary Civil Commitment in Winston-Salem* (1982).

> A number of community representatives in Winston-Salem unhappily report that when patients are released (prior to or following a hearing), family members and other interested parties often do not receive notification of the release. Facility personnel admit that they have no clear policies for providing notification upon discharge. To the extent that respondents are entitled to prevent the facility from notifying family members and others of their detention or commitment, it is reasonable to suggest that they should be entitled to prevent the hospital from notifying these persons of their release as well. If, as is recommended above, upon release of respondent prior to hearing, the facility notifies the court and the court, in turn, notifies respondent's counsel, the district attorney, the petitioner, and witnesses summoned to appear at the hearing, most necessary notifications will be taken care of. An additional question, however, is whether notification should be made to persons in the community whose safety may be threatened by the respondent once he or she is released. Although no one in Winston-Salem appears to be terribly concerned about this, perhaps because any significant threat would indicate sufficient dangerousness to warrant holding a hearing, personnel of mental health facilities in other cities we visited feel that it is a vitally important question. In one city in particular, persons frequently are hospitalized as a result of their allegedly having made threats against public officials or other public figures. In these cases, facilities in the city have a policy that facility staff notify the person allegedly threatened immediately upon the patient's release. In order to better protect the safety of the community and the legal interests of the releasing facilities and their staff, a similar policy should be considered in Winston-Salem.

Id. at 55. *See also* Fitch, *supra* note 4, at 433-34.

6. *See also* S. Brakel, J. Parry, & B. Weiner, *supra* note 1, at 208-09.

PART E
LEGAL REPRESENTATION

The presence of a lawyer in involuntary civil commitment proceedings is today routine. By statute, most states require that legal counsel be appointed to represent persons subject to involuntary civil commitment.[1] Where statutes do not provide for mandatory legal assistance, legal counsel still may be required by state or federal court rulings.[2] Beyond the widespread recognition of the key role assumed by defense counsel in involuntary civil commitment cases[3] and the provision for mandatory legal counsel to respondents in most states, the precise nature of the lawyer's role and duties in commitment proceedings is unclear.4 The seven guidelines in Part E define that role and prescribe those duties.

The first guideline in this part, "Ensuring Effective Counsel for Respondents," suggests the necessary organizational and administrative structure of legal representation to be provided to respondents. Guidelines E2 and E3 prescribe the proper roles, duties, and responsibilities of defense counsel as well as the counsel for the state. Guidelines E4 through E7 further define the role, duties, and responsibilities of respondents' counsel by detailing the meaning of effective counsel during the crucial prehearing stages of involuntary civil commitment. By encouraging the active involvement of the lawyer long before a court hearing, these guidelines are compatible with the importance that is ascribed to the early stages of commitment throughout this guidebook.[5]

Notes

1. D. Hermann, *Representing the Respondent in Civil Commitment Proceedings* 11-13 (1985). *See* S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* 284-89 (1985).

2. *See* D. Hermann, *id*. at 14; Elkins, *Legal Representation of the Mentally Ill*, 82 W. Va. L. Rev. 157, 157-58 (1979).

3. *But see* Appelbaum, *The Rising Tide of Patients' Rights Advocacy*, 37 Hosp. & Community Psychiatry 9 (1986) (questioning the desirability of an increasing number of patients' rights advocates in the mental health arena).

4. "The lack of delineation of duties is a fatal flaw and contributes to, rather than resolves, the conflict in the lawyer's role. The mere statutory right to a lawyer at the commitment hearing is inadequate if the scope of the lawyer's duties is not outlined." D. Hermann, *supra* note 1, at 13. *See also* Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 Yale L.J. 1540 (1975).

5. The duties of respondents' counsel during and after judicial hearings are delineated in Guidelines F5 and H1.

E1. Ensuring Effective Counsel for Respondents

The organization and administration of legal representation of respondents in involuntary civil commitment proceedings should be structured to ensure effective counsel.

(a) Specialized training and frequent involvement in representing civil commitment respondents enhance the quality of the legal representation provided. To be eligible for appointment, attorneys should take specialized courses or receive supervised on-the-job training in the duties, skills, and ethics of representing civil commitment respondents.

(b) To ensure effective legal representation of respondents, most of whom are indigent, appointed counsel should be provided in two ways. First, if available in the community, a legal services agency, such as a public defender or legal aid society, should be appointed regularly to represent respondents. Second, a panel of private attorneys eligible for appointment should be established and maintained.

(c) Social workers, in coordination with mental health screening officers, should be available to attorneys to investigate the facts of cases and to locate appropriate resources in the community that may serve as viable alternatives to involuntary civil commitment.

(d) To ensure that attorneys understand their role and duties and effectively represent their clients, a clear statement of the role and duties of respondents' attorneys in civil commitment cases should be prepared by the legal organization or agency regulating legal representation in civil commitment proceedings.

Commentary

Adequate legal representation of persons facing involuntary civil commitment cannot be provided on an *ad hoc* basis. Guideline E1 recommends, in general terms, the organizational and administrative arrangements that are most likely to result in effective legal representation.[1] The guideline prescribes a system that relies primarily on representation by either a knowledgeable, full-time legal staff of a legal services organization[2] or a special panel of appointed counsel. The guideline is not intended, however, to prevent those private practitioners who would want to represent respondents on an occasional, perhaps *pro bono*, basis from doing so, but such attorneys should be encouraged to take continuing legal education courses

or other training relevant to the representation of respondents in civil commitment proceedings.

Whenever possible, a legal services organization, such as a public defender or legal aid society, should be used to represent persons who are subject to civil commitment proceedings. Legal services organization attorneys should receive specialized training regarding the duties, skills, and ethics of representing civil commitment respondents. To assist legal services organization attorneys in investigating the facts of cases and alternative placements for clients, the organization's staff should include full-time social workers. If the number of cases is insufficient to justify full-time social workers, then the organization should hire part-time social workers or contract with other agencies for these services. In addition, a panel of private attorneys eligible for appointment to represent civil commitment respondents should be established and maintained either to supplement legal services organization representatives or to represent civil commitment respondents where a legal services organization is unavailable. Specialized training regarding the duties, skills, and ethics of representing civil commitment respondents should be required before an attorney is included on the panel. The number of attorneys on the panel should be gauged to permit each attorney sufficiently frequent involvement in civil commitment cases to maintain the quality of representation provided.

Guideline E1 recognizes that adequate representation of respondents requires access to information and expertise that most attorneys do not have. Accordingly, the guideline prescribes that social workers assist attorneys in investigating the client's case and exploring various mental health and social services available to the respondent. Ideally, a social worker should be assigned to every involuntary civil commitment case to assist the attorneys and the court in identifying the least restrictive, appropriate treatment and care and to monitor respondents' compliance with conditions of negotiated settlements and court orders.[3] In all cases, social workers should consult and work in cooperation with the mental health screening officer.

Notes

1. Although there are some distinct advantages to the representation provided by a full-time legal staff with supporting services, see Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 Calif. L. Rev. 816, 826 (1974), the substantial expenditures and resources that such an arrangement would entail may make it impractical, if not impossible, in many rural jurisdictions.

2. An example of a state-supported legal defense system is New York's Mental Health Information Service, which began operation in 1965 and is providing representation to respondents in some jurisdictions in the state. *Id.* at 819.

"Only full-time patient advocates can be expected to have the time, the expertise, the relative freedom from governmental pressures, and the sense of commitment to adequately represent clients who are likely to be poor, disturbed, and otherwise alone in defending their rights." *Id.* at 839.

3. Although social workers may play a very valuable role in exploring less restrictive alternatives and ensuring respondents' compliance with treatment and care less restrictive than involuntary hospitalization, the role may be viewed from a purely adversarial perspective as entailing an inherent conflict of interest. As long as a social worker serves at the pleasure of the respondent's counsel to explore available options for treatment and care, little conflict arises except that which may occur when the judgment of the social worker differs from that of the attorney. A conflict may arise, however, if a social worker's role includes monitoring of a respondent's compliance with conditions imposed by negotiated settlement of the case or by court order. *See* I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 112-13 (1983).

E2. Respondent's Counsel as Advocate and Advisor

Involuntary civil commitment is a complex process reflecting the various perspectives of the individuals, groups, agencies, and institutions charged with its administration. The proper role of the attorney representing the respondent in this process is a controversial issue that engenders much confusion and misunderstanding, even among attorneys themselves. From a legal perspective, the commitment process is adversarial and involves fundamental liberty issues. Thus, the primary role of a respondent's counsel is to represent the perspective of the respondent and to serve as a vigorous advocate for the respondent's wishes.

To assume the proper advocacy role, the attorney must advise the respondent of all available options, as well as the practical and legal consequences of those options. The attorney should also help the respondent define his or her objectives by advising him or her about the probability of success in pursuing any one of those options. If the respondent expresses a desire to seek voluntary mental health treatment or related social services, the attorney should give the respondent the necessary and appropriate advice or assistance to pursue those desires. This role of advocate and advisor should be based on knowledge of the range of services available to the client and, if possible, consultation with a social worker (see paragraph (c) of Guideline E1) or a mental health screening officer (see Guideline B2).

The attorney's responsibilities to his or her client should continue for as long as the client is an involuntary patient. To the extent that a client is unable or unwilling to express personal wishes, the attorney should advocate the position that best safeguards and advances the client's interests.

Commentary

Although the diagnosis and treatment of mental illness are matters entrusted primarily and appropriately to mental health professionals, the decision to force a person

into a mental hospital or other treatment and care setting is a legal matter.[1] Beginning in the 1960s,[2] recognition of the "massive curtailment of liberty"[3] that involuntary civil commitment entails led to the provision of due process rights for persons subject to commitment proceedings, including the right to be represented by legal counsel. Legislatures[4] and courts[5] throughout the country have recognized the right to counsel in civil commitment proceedings. Few, however, have addressed the proper role of the attorney.6 Thus, Guideline E2 addresses not the settled question of whether a person should be represented by counsel,[7] but rather the question of what role counsel should assume.

The role of a respondent's attorney is to be an advocate for the respondent's expressed wishes regarding the outcome of the commitment proceedings. Simply put, the attorney stands up for someone who has no one else to stand up for him or her, and who may be ill-equipped to do so personally. This role is often misunderstood. The attorney should not adopt the functions of the judge or jury by attempting to balance the needs of the respondent with those of the community or the family.

That the attorney should be an advocate derives from the notion that commitment is an adversary process in which the liberty of an allegedly mentally ill person is at issue. The adversary process assumes that the best way to achieve justice is for the attorney for each party to present the case in the manner most favorable to his or her client.[8] A judge then acts as a neutral decisionmaker, assessing the conflicting evidence and determining the outcome according to established legal standards.[9]

The attorney also should not act as a guardian *ad litem*,[10] because the court, not the attorney, should decide whether the respondent is committable.[11] When an attorney fails to act as an advocate and assumes a paternalistic or passive stance, "the balance of the system is upset, the defense attorney usurps the judicial role, and the defendant's position goes unheard."[12]

Unfortunately, in practice, the attorney's role often has been ill-defined. One commentator has described the situation as a problem of the attorney's "rolelessness."[13] For example, a recent survey of attorneys who represent respondents in North Carolina indicated that attorneys preferred a paternalistic model of civil commitment proceedings.[14] A study in Arizona revealed that most attorneys viewed their role as one of guarding the procedural rights of the respondent.[15] As one attorney put it, his role was to see that "only those patients needing commitment were committed."[16] Finally, a survey of Iowa attorneys indicated that eighty-two percent viewed their role as being different from representing clients in other kinds of cases, because commitment may be in a client's best interests.[17]

The weight of legal authority supports the position taken by Guideline E2, that a respondent's attorney should function as an advocate. Legal scholars recommend that the attorney should be an advocate.[18] Although only four state legislatures have addressed the issue, all four take the position that the attorney should be an advocate.[19] Courts that have addressed the question have taken the same position.[20]

Generally, consistent with Guideline E2, the attorney should advocate the client's expressed wishes. The limits of the advocacy role are tested, however, when because of his or her disabling condition the client is unable or unwilling to express his or her wishes regarding the outcome of the commitment proceedings. The National Task Force takes the position that "[t]o the extent that a client is unable or unwilling to express his or her wishes, the attorney should advocate the position that best safeguards and advances the client's interest in liberty."[21] This does not mean that the attorney in every case should advocate outright release from detention and dismissal of the commitment petition. Advocating such a position may be contrary to the client's liberty interest. For example, if the client is exhibiting bizarre behavior that suggests severe psychosis and poses a clear threat to others, the court may flatly reject the attorney's efforts to secure release of the client.[22] In such cases the attorney should advocate the position that best safeguards and advances liberty, that is, the position that provides a realistic probability of acceptance by the court. If outright release is unlikely, the attorney should advocate the least restrictive alternative that the court is likely to accept under the circumstances of the case.

The need for an attorney to make judgments in the absence of a client's expression of wishes and desires should arise infrequently. Mental illness *per se* is not incompetence.[23] Guideline E2 requires that the attorney advocate the client's wishes to the extent that they are expressed. In this regard, the guideline follows the Model Rules of Professional Conduct,[24] which require that when a client is under a disability, "the lawyer *shall*, as far as reasonably possible, maintain a normal client-lawyer relationship with the client."25 The guideline goes beyond the Model Rules, however, by defining the attorney's responsibility when a normal client-lawyer relationship cannot be maintained.[26] The Model Rules say only that the "lawyer may seek the appointment of a guardian or take other protective action with respect to the client, only when the lawyer reasonably believes that the client cannot adequately act in the client's own interest."[27] The guideline instructs the attorney about how to exercise this broad discretion within the involuntary civil commitment context with a client who fails to express his or her wishes.

Guideline E2 prescribes the role of the respondent's attorney in general terms. With two exceptions, the guideline does not define that role in terms of specific functions or activities. This is done in the guidelines that follow in this part. The two specific propositions addressed here are that the attorney should have a thorough knowledge of the services available to the client[28] and

that, if possible, the attorney should consult with a mental health screening officer[29] in representing his or her client. These two responsibilities are important for two reasons. First, they enhance the attorney's ability to advise a client regarding the available options and to assist the client who chooses a voluntary alternative to commitment. Second, they increase an attorney's ability to advocate a client's wishes insofar as the attorney is able, for example, to assess the options available to the client and the probability of persuading the court or prehearing treatment and care providers that, in light of the options, commitment to a hospital is unnecessary.

Advocacy is not synonymous with confrontation.[30] In representing a client's interests during the prehearing portion of the commitment process,[31] for example, confrontation may destroy the chance of working cooperatively with other professionals to arrange a voluntary alternative for the client. If the attorney makes a prehearing examiner aware that the attorney is concerned about the client, not about "winning" a case or uncovering irregularities in the examination process, then cooperation and, ultimately, the client's case are advanced. Although vigorous cross-examination of a prehearing examiner may be appropriate during a commitment hearing,[32] it is not appropriate before the hearing.[33] During the prehearing period, the attorney should monitor the actions taken with regard to the client, but should confront responsible persons only if necessary to protect the respondent.

Notes

1. *See* Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C.L. Rev. 1027, 1045 (1982).

2. *See* McGraw, Fitch, Buckley, & Marvell, *Civil Commitment in New York City: An Analysis of Practice*, 5 Pace L. Rev. 259, 260 (1985).

3. *Humphrey v. Cady*, 405 U.S. 504, 509 (1972).

4. *E.g.*, Alaska Stat. § 47.30.725(d) (1984); Del. Code Ann. tit. 16, § 5006(3) (1983); Ga. Code Ann. §§ 37-3-44(a), 37-3-141 (1982); Ind. Code Ann. ?? 16-14-9.1-9(e)(4) (Burns Supp. 1985); Mass. Gen. Laws Ann. ch. 123, § 5 (West Supp. 1985); *see also* D. Hermann, *Representing the Respondent in Civil Commitment Proceedings* 11-13 (1985).

5. *E.g., In re Barnard*, 455 F.2d 1370 (D.C. Cir. 1971); *Heryford v. Parker*, 396 F.2d 393 (10th Cir. 1968); *Lessard v. Smith*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975); *Dixon v. Attorney General*, 325 F. Supp. 966 (M.D. Pa. 1971); *see also* D. Hermann, *supra* note 4, at 14-17.

6. *See infra* notes 19-20 and accompanying text.

7. *See* Stefan, *Right to Counsel in Civil Commitment Proceedings*, 9 Mental & Physical Disability L. Rep. 230 (1985).

8. Hiday, *supra* note 1, at 1029.

9. *Id*. (citing J. Frank, *Courts on Trial: Myth and Reality in American Justice* (1949)); Barrett, *The Adversary System and the Ethics of Advocacy*, 37 Notre Dame Law. 479 (1962)); Note, *The Role of Counsel in the Civil Commitment Process: A Theoretical Framework*, 84 Yale L.J. 1540 (1975); Zander, *Civil Commitment in Wisconsin: The Impact of Lessard v. Schmidt*, 1976 Wis. L. Rev. 503.

10. Some older court decisions take the view that a respondent's attorney should act as a guardian *ad litem*, that is, that the attorney should determine what is in his or her client's best interests and should represent the client in accordance with that determination, regardless of the client's expressed wishes. *See, e.g., In re Basso*, 299 F.2d 933 (D.C. Cir. 1962); *Prochaska v. Brinegar*, 251 Iowa 834, 102 N.W. 2d 870 (1960). *But see infra* note 20 and accompanying text.

11. Hiday, *The Role of Counsel in Civil Commitment: Changes, Effects, and Determinants*, 5 J. Psychiatry & L. 551, 564 (1977); Blinick, *Mental Disability, Legal Ethics, and Professional Responsibility*, 33 Albany L. Rev. 92, 115 (1968).

12. Zander, *supra* note 9, at 515.

13. Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 Tex. L. Rev. 424, 425, 446 (1966).

14. Hiday, *supra* note 1, at 1036.

15. D. Wexler, *Mental Health Law: Major Issues* 97 (1981).

16. *Id.*

17. Contemporary Studies Project, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation,* 64 Iowa L. Rev. 1284, 1396 (1979).

18. Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 Miss. L.J. 43, 48, 89 (1974); Note, *supra* note 9; D. Hermann, *supra* note 4, at 33-35; Hiday, *supra* note 1, at 1045-47; Hiday, *supra* note 11, at 566; Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 Calif. L. Rev. 816, 827-31 (1974): Perlin & Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 Law & Contemp. Probs. 161, 168 (1982). *But see* Brakel, *The Role of the Lawyer in the Mental Health Field*, 1977 A.B. Found. Research J. 467; Woody, *The Lawyer in the Mental Health Field: Beyond Brakel*, 1979 A.B. Found. Research J. 211.

19. Minn. Stat. Ann. § 253B.03(9) (West 1982) (counsel shall "be a vigorous advocate on behalf of his client"); Miss. Code Ann. § 41-21-102(8) (Supp. 1985) (counsel shall "be a vigorous advocate on behalf of his client"); Tex. Rev. Civ. Stat. Ann. § 5547-45(a) (Vernon Supp. 1986) ("If the person expresses a desire to avoid court-ordered mental health services, the attorney has the duty to use all reasonable efforts within the bounds of law to advocate the person's right to avoid court-ordered mental health services, without regard to the attorney's personal view."); Wis. Stat. Ann. § 51.20(3) (West Supp. 1985) ("court shall assure that the subject individual is represented by adversary counsel"). By implication, Iowa statute also requires an advocate role. Iowa Code § 229.12 (1985) (hearings shall be conducted in an adversarial manner). Tenn. Code Ann. § 33-3-608 (West Supp. 1985) states that an attorney representing a respondent shall not serve as guardian *ad litem*. Only Alabama's statutory law takes the position that the attorney may be the same person as the guardian *ad litem*. Ala. Code § 22-52-4(a) (1984).

20. *State ex rel. Memmel v. Mundy*, 75 Wis. 2d 276, 283, 249 N.W.2d 573, 576-77 (1977); *Quesnell v. State*, 83 Wash. 2d 224, 231, 517 P.2d 568, 575-76 (1974). *See also Lessard v. Schmidt*, 349 F. Supp. at 1099.

21. Guideline E2.

22. *See* Litwack, *supra* note 18.

> The attorney need not argue that the client is not "mentally ill" if indeed the client's manner and behavior, and the strength of the psychiatric testimony, make the position untenable. Other equally effective arguments can be made instead. For example, the attorney can contend that the patient is not dangerous, is not in need of hospitalization, or would benefit more from an outpatient program. Moreover, the attorney can always challenge psychiatric testimony to the contrary, since issues regarding future events will rarely be clearcut and will necessarily involve uncertain predictions.

Id. at 831 (footnote omitted).

23. Even civil commmitment generally does not establish that a person is incompetent. *See, e.g.*, Mo. Ann. Stat. §630.120 (Vernon Supp. 1985). *But see Stensvad v. Reivitz*, No. 84-C-383-S (W.D. Wis. Jan. 10, 1985) (ruling that under Wisconsin law, civil commitment is a finding of incompetency with respect to treatment decisions).

24. The Model Rules of Professional Conduct (hereinafter cited as Model Rules), drafted by the American Bar Association Commission on Evaluation of Professional Standards and adopted by the House of Delegates of the American Bar Association on August 2, 1983, contains the rules of conduct that govern the legal profession. The Model Rules or its predecessor, the Model Code of Professional Responsibility, has been adopted by most states.

25. Model Rules, *supra* note 24, Rule 1.14(a) (emphasis added):

> When a client's ability to make adequately considered decisions in connection with the representation is impaired, whether because of minority, mental disability or for some other reasons, the lawyer *shall*, as far as reasonably possible, maintain a normal client-lawyer relationship with the client.

26. The Model Rules contain only a general statement of what an attorney *may* do under these circumstances. *See infra* note 27 and accompanying text. *See generally* Devine, *The Ethics of Representing the Disabled Client: Does Model Rule 1.14 Adequately Resolve the Best Interests/Advocacy Dilemma?*, 49 Mo. L. Rev. 493 (1984).

27. Model Rules, *supra* note 24, Rule 1.14(b) (emphasis added). The preamble to the Model Rules emphasizes that whenever a rule is cast with the term "may," the rule is "permissive and define[s] areas in which the lawyer has professional discretion." It also states that the rules do not "exhaust the moral and ethical considerations that should inform a lawyer."

28. *See* Guideline A2, "Continuum of Services: Directory."

29. *See* Guideline B2, "Mental Health Screening Officer."

30. Litwack, *supra* note 18, at 828 ("an adversarial — though not necessarily hostile — stance" is required).

31. *See* Guideline D4, "Prehearing Examination Procedures," and Guideline D5, "Prehearing Examination Reports."

32. *See* Guideline F5, "Duties of Respondents' Attorneys during Hearings."

33. *See* Blinick, *supra* note 11, at 115; Andalman & Chambers, *supra* note 18, at 47.

E3. Counsel for the State

Because it is an adversarial proceeding, an important premise of involuntary civil commitment is that justice is best served when opposing attorneys present evidence most favorable to their clients.

A district attorney, county attorney, or other appropriate public attorney should represent the public's interest in all involuntary civil commitment proceedings. This attorney should refrain from proceeding with commitment in cases that he or she reasonably believes do not warrant commitment.

Commentary

Involuntary civil commitment involves at least three complex and often competing interests: those of the respondent, those of the family, and those of the community. The respondent has an interest in being left alone, and if compelling reasons exist for infringing on his or her freedom, the respondent then has an interest in being treated fairly, honestly, and as well as possible. The family and the respondent's circle of friends and acquaintances have interests in making sure that the respondent is given the care and treatment that he or she needs but may be unwilling or unable to obtain voluntarily. They also have an interest in alleviating the burden that a failure to provide treatment and care to the individual may have caused. The state has two interests: first, under its police power, to protect its citizens from dangerously mentally ill persons, and second, according to the *parens patriae* doctrine, to care for its sick and helpless. In carrying out its duties, the state also has an obligation to do so as efficiently and economically as possible. That is, unreasonable programmatic, fiscal, and administrative burdens should not be imposed.

Guideline E3 requires that the public's interests, including those of the state and family members, have legal representation in commitment proceedings, including prehearing activities, such as settlement negotiations. In the absence of legal representation of the public's interests, a full presentation of all relevant facts and a proper balance among the competing interests of the respondent, the family, and the state is difficult to achieve.[1] Opposing attorneys, presenting those facts most favorable to their clients, release a judge to be a neutral decision-maker instead of assuming an awkward, dual role of "examiner" as well as judge.[2] Even if a judge assumes this dual role by questioning the respondent and other witnesses, the resulting imbalance in the adversarial system is not corrected, because the judge is largely restricted to assuming this dual role only at the time of commitment hearings. Even there, he or she is limited to questioning only those witnesses who are present, which may be only those who are favorable to the respondent.

Lack of opposing counsel may also have a detrimental effect on the quality of the legal representation provided to a respondent. When proceedings are not clearly adversarial in nature, the respondent's attorney may be confused about his or her proper role.3

Guideline E3 provides that opposing counsel should represent the interests of the "public." Technically, the "represented party" is determined by statute[4] or local custom. For example, an associate attorney general's role is defined by North Carolina statute as "representing the state's interest."[5] It is unclear whose interests are represented and who is the attorney's "client." The North Carolina Division of Mental Health, Mental Retardation and Substance Abuse Services had construed his or her role as representing the views of the hospital physicians. However, according to the North Carolina attorney general's office, the associate attorney general represents the views of both the hospital physicians and the petitioners, whose views may frequently differ.[6]

In advocating that an attorney represent the public's

interest in involuntary civil commitment proceedings, the guideline suggests that the attorney for the state, like the respondent's attorney (see Guideline E2), must attempt to balance a number of competing interests, including those of the state, the family or friends of the respondent, the admitting or treating physicians, and community mental health personnel. Depending on the stage of the proceedings and statutory provisions, any one of these may be the "moving party" in a technical sense. For example, in emergency situations, a police officer may have apprehended a respondent and taken him or her into custody at the request of family members and then filed with the court an application for emergency treatment. In such cases, the state (i.e., the police officer) is the moving party, even though family members were the initial cause of the police officer's intervention. After a short period of emergency treatment, the director of the treatment facility may formally petition the court for continued involuntary treatment and care of the respondent pending a judicial hearing. In nonemergency cases, family members seeking the involuntary civil commitment of a respondent may act as "applicants" (not necessarily the moving party in a legal sense). The public agency to which the application is submitted reviews the application and becomes the moving party that petitions the court only if it deems that the case for involuntary civil commitment has merit.

Guideline E3 recognizes that the counsel for the state should have an obligation to weigh a number of competing interests in a way that may not coincide with the traditional model of a lawyer advocating the interests of a single client or a prosecutor advocating justice or arguing the case against a criminal defendant. Strictly speaking, the role of counsel for the state will vary depending upon who the petitioner is — whether the petitioner for commitment is a private individual or a public agency. If the petitioner is a public agency, the attorney's role will be much like that of a criminal prosecutor arguing the case for commitment. But a prosecutor may exercise "prosecutorial discretion" and decide not to proceed with an unmeritorious case. Likewise, counsel for the state should carefully review a petition for commitment and make an independent judgment regarding whether to pursue involuntary civil commitment. When the petitioner is a public agency, however, counsel for the state should not ignore the interests and concerns of the "applicants" (i.e., family members or other private persons who sought to have the public agency petition for commitment). Though the attorney's first responsibility is to represent the interests of the state petitioner, Guideline E3 imposes an obligation to be solicitous of the applicant's interests and concerns in deciding how the public's interests (which include those of the applicant) can best be represented.

Alternatively, if the petitioner for commitment is a private individual, the attorney's first obligation must be to represent the interests of the petitioner. Still, Guideline E3 imposes upon the attorney for the state the duty to consider the public's interests in not proceeding with unmeritorious cases and to refrain from pressing for commitment in cases involving persons who the attorney believes are not fit subjects for involuntary civil commitment. In cases in which the counsel for the state chooses not to press for commitment, Guideline E3 does not preclude the petitioning party or a family member from retaining private counsel in order to pursue involuntary civil commitment.[7]

Like the respondent's attorney, the counsel for the state should assist his or her client (e.g., private petitioner or state psychiatrist) in defining objectives by advising the client of the options available for compulsory treatment and care, the consequences of each, the probability of successfully pursuing such options, and the counsel's recommended course of action. Such activities on the part of the counsel for the state may take place early in the commitment proceedings, as in settlements of the cases negotiated between respondent's counsel and counsel for the state.[8]

Notes

1. *See* Hiday, *The Role of Counsel in Civil Commitment: Changes, Effects, and Determinants*, 5 J. Psychiatry & L. 551, 566 (1977); Hiday, *The Attorney's Role in Involuntary Civil Commitment,* 60 N.C.L. Rev. 1027, 1029 (1982); Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 Tex. L. Rev. 424, 448 (1966); D. Hermann, *Representing the Respondent in Civil Commitment Proceedings* 9-10 (1985).

2. Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 Calif. L. Rev. 816, 830 (1974); Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 Miss. L.J. 43, 76 (1974); Cohen, *supra* note 1, at 448.

3. See D. Hermann, supra note 1.

4. Ala. Code § 22-52-5 (1984) (an attorney, appointed by the probate judge, will serve as "the advocate in support of the petition" unless the petitioner desires his own attorney); Ariz. Rev. Stat. Ann. § 36-503.01 (Supp. 1985) (the attorney general or the county attorney shall represent the individual or agency petitioner and defend against challenges to the commitment); Ark. Stat. Ann. § 59-1413 (Supp. 1985) (the county prosecuting attorney's office shall represent the petitioner "regardless of the petitioner's financial status" unless the petitioner desires his or her own attorney; the prosecutor shall be immune from civil liability in performing this official duty); Cal. Welf. & Inst. Code § 5114 (West 1984) and Cal. Gov't Code §§ 26530, 27646 (West Supp. 1986) (unless delegated to the county counsel, the district attorney shall present the allegations of mental illness at the proceedings); Colo. Rev. Stat. § 27-10-111(5) (Supp. 1985) (the district attorney, the county attorney in areas of more than one hundred thousand population, or a court-appointed, qualified attorney in either's place shall conduct all of the proceedings); Fla. Stat. Ann. § 394.467(3)(a) (West Supp. 1985) (the state attorney shall represent the state); Hawaii Rev. Stat. §§ 334-60.3(a), -60.5(e) (Supp. 1984) (the attorney general or his or her deputy, special deputy, or appointee designated to present the case shall assist the petitioner in writing the petition and shall present the case unless the petitioner has retained his or her own counsel); Ill. Ann. Stat. ch. 91 1/2, § 3-101 (Smith-Hurd Supp. 1985) (the state's attorney shall represent the state, shall attend the proceedings in person or by assistant, and shall ensure that petitions, reports, and orders are properly prepared; any party may be represented by his or her own counsel); Iowa Code Ann. § 229.12(1) (West 1985) (the county attorney shall present evidence in support of the contention made in the application); Kan. Stat. Ann. § 59-2912(f), -2914(b), -2917 (1983) (an applicant without an attorney shall be represented by the county or district attorney, who shall prepare all necessary papers, appear at the hearing,

and present the evidence necessary to aid in the court's decision); Ky. Rev. Stat. § 202A.016 (1982) (the county attorney has the duty to assist the petitioner, to represent the interests of the commonwealth, and to assist the court through the presentation of evidence); La. Rev. Stat. Ann. § 28:54(A) (West Supp. 1986) (a petitioner who is unable to afford an attorney may seek the assistance of any legal aid society or similar agency if available); Mich. Comp. Laws Ann. § 330.1457 (West 1980) (the county prosecuting attorney shall participate, either in person or by assistant, in the hearings unless the petitioner or "other appropriate person" has retained private counsel to present the case); Minn. Stat. Ann. § 253B.07(1)(a), (1)(c), (1)(e), (7)(b) (West Supp. 1986) (the county attorney shall petition for commitment of insanity acquittees; receive the prescreening team's recommendations for all commitments; determine, at petitioner's request, whether to proceed if the petitioner disagrees with the recommendations of the prescreening team; and attend the preliminary hearing); Mo. Ann. Stat. § 632.405 (Vernon Supp. 1986) (the county prosecuting attorney shall represent the petitioner and file and prosecute all commitment petitions); Mont. Code Ann. §§ 53-21-121(1), -123(1), -123(2)(a), -124 (1984) (the county attorney may file a commitment petition upon anyone's request, receive a copy of the mental examination, request an additional examination if the first such examination recommends dismissal, and request the detention of the respondent pending the hearing); Neb. Rev. Stat. §§ 83-1024, -1026, -1036, -1075 (1981) (the county attorney shall draft and act upon a petition if he or she concurs with an applicant that the respondent is mentally ill; the county attorney will decide if the immediate custody of the respondent is necessary, and he or she has the discretion to dismiss the petition at any time before the hearing; the county attorney may also apply for the reinstatement of the petition should it be dismissed at the hearing; at a rehearing, the attorney general has the same duties and powers as the county attorney at an initial hearing); Nev. Rev. Stat. § 433A.270(4) (1983) (the district attorney or his or her deputy shall appear and represent the state and is responsible for the presentation of evidence); N.H. Rev. Stat. Ann. § 135-B:4 (Supp. 1985) (the attorney general or his or her designee shall represent the state in proceedings in which the state is an interested party); N.J. C.P.R. 4:74-7(e) (in no case shall the patient appear *pro se*); N.J. Stat. Ann. § 30:4-34 (West Supp. 1985); *In re Alfred*, 137 N.J. Super. 20, 347 A.2d 539 (1975) (the applicant may appear either by counsel retained by him or her or by the county adjuster; the county adjuster will represent the state); N.M. Stat. Ann. § 43-1-11(E) (1984) (if the district attorney determines that there are reasonable grounds, he or she may petition for commitment); *People v. Flockhart*, 96 A.D.2d 843, 465 N.Y.S.2d 601 (1983) (although the district attorney may attend, he or she may participate in the proceedings only if called upon to present evidence by one of the parties or the court); N.C. Gen. Stat. § 122C-270(f) (Supp. 1985) (the attorney general will represent the state's interest); N.D. Cent. Code § 25-03.1-14 (Supp. 1985) (the state's attorney shall represent the state); Ohio Rev. Code Ann. § 5122.15(10) (Page Supp. 1984) (an attorney designated by the attorney general shall present the case; however, in an insanity acquittee's proceeding, the prosecutor shall present the case while another attorney, designated by the attorney general, will represent the hospital to which the respondent was committed; in presenting the case, evidence of the diagnosis, prognosis, record of treatment and less restrictive treatment plans will be shown); Okla. Stat. Ann. tit. 43A, § 55.1 (West 1979) (the district attorney shall represent the state and prepare and prosecute all proceedings); Or. Rev. Stat. § 426.100(4) (1985) (the district attorney or counsel appointed by the county governing board shall assist, upon the court's request, in the conduct of the hearings); S.D. Codified Laws Ann. § 27A-9-4 (1984) (the state's attorney shall represent the individual or agency petitioners and defend against challenges to the commitment); Tex. Rev. Civ. Stat. Ann. art. 5547-13 (Vernon Supp. 1985) (the county or district attorney shall represent the state); Vt. Stat. Ann. tit. 18, § 7616 (Supp. 1985) (the state's attorney or the attorney general at his or her discretion shall represent the state, have the burden of proving the case by clear and convincing evidence, and may dismiss the application at any stage of the proceedings); Va. Code § 37.1-104.2 (1984) (the commonwealth's attorney, upon request by the hospital, shall represent the state in opposition to any petition, appeal, or procedure for the discharge of a person from custody); Wash. Rev. Code Ann. § 71.05.130 (Supp. 1986) (the county prosecuting attorney shall represent the individuals or agencies petitioning for commitment and defend against challenges to the commitments; the attorney general shall represent and provide legal services to state hospitals except in fourteen-day-detention hearings initiated by the state hospital); W. Va. Code §§ 27-5-1(c), -5-1a (1980 & Supp. 1984) (the prosecuting attorney or his or her assistants shall represent the applicants; should the number of cases be burdensome, the court shall appoint an attorney to act in a case; the appointed attorney shall receive a reasonable fee, similar to that of an attorney representing an indigent, from the "mental hygiene fund"); Wis. Stat. Ann. § 51.20(4) (West Supp. 1985) (The district attorney or the corporation counsel, if designated, or other counsel shall represent the interests of the public, including the drafting of all necessary papers); Wyo. Stat. § 25-10-110(c) (1982) (the county attorney shall appear in the public interest).

5. N.C. Gen. Stat. § 122C-270(f) (Supp. 1985).

6. Miller, *Involuntary Commitment of the Mentally Ill in North Carolina: A Physician's View*, Popular Government, Spring 1983, at 31.

7. The American Psychiatric Association, in its model state law on involuntary civil commitment, prescribes the optional provision that if the state fails to proceed with commitment, private counsel retained by the next of kin or a petitioning party shall be paid by the state or local government. *See* Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 Harv. J. on Legis. 275, 339 (1983) (compensation to such privately retained counsel would be limited to "reasonable" costs). The National Task Force took no position on the issue of compensation provided privately retained counsel.

8. In Milwaukee County, Wisconsin, for example, negotiated settlements take two forms: "court-ordered voluntary" agreements, which result in voluntary inpatient status, and stipulated settlements, which result in outpatient status. A negotiated settlement results from relatively unstructured conferences and negotiations between the attorney representing the respondent and the Milwaukee corporation counsel, who represents the state. These conferences and negotiations generally occur prior to the probable cause hearing, but may follow it. The parties negotiate, reach an agreement, and then seek postponement of the probable cause hearing or final commitment hear-ing for a specified time, during which the respondent participates in the agreed-upon treatment program. Unless the respondent fails to comply with the terms of the agreement, the matter is dismissed at the end of the treatment period. If the respondent has failed to comply, the corporation counsel requests that the case be reopened. *See* I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 72 (1983).

E4. Appointing Attorneys for Respondents

To ensure that respondents receive proper legal counsel, a legal services organization or an attorney from a panel of attorneys should be appointed for any respondent without counsel, regardless of the respondent's ability to pay. If a respondent wishes to waive counsel and exercise the right of self-representation allowed by law, the court should determine that the waiver is clear, knowing, and intelligent. If waiver is allowed, the court should require an attorney to remain available in the event that the respondent later requests counsel or the court otherwise requires the respondent to be represented.

(a) To protect the interests of persons who are subject to commitment proceedings and to permit sufficient time for respondents' attorneys to prepare their cases, attorneys should be appointed when commitment proceedings are first initiated.

(b) The manner in which attorneys are appointed from the panel of attorneys eligible to represent civil commitment respondents should safeguard the autonomy of attorneys in representing their clients. To accomplish this objective, an independent third party, such as the local bar association or a legal services organization, should be responsible for maintaining the panel. The court should appoint attorneys from that panel serially, unless an attorney's absence or other compelling reasons require otherwise.

(c) Paying appointed private attorneys a flat fee or placing a ceiling on pay for each civil commitment case defended provides a disincentive for attorneys to prepare cases properly. Therefore, assigned counsel should be paid a reasonable hourly rate. To ensure, however, that attorneys charge only for time reasonably spent working on cases, attorneys should be required to submit for court approval statements for professional services rendered for review and careful screening.

(d) Respondents financially able to employ an attorney, but mentally incapable of intelligently deciding whether to employ one, should be provided appointed counsel. The state should be reimbursed by respondents for whom legal representation is provided in this manner.

Commentary

Most state statutes require that an attorney be appointed for any respondent who is indigent.[1] Some states also require that legal counsel be appointed if the respondent is incompetent[2] or refuses to retain counsel.[3] A significant minority of states require that an attorney be appointed for any respondent who, for any reason, does not have an attorney at the time the appointment decision must be made.[4] Guideline E4 similarly requires appointment of counsel for all respondents. As discussed below, a respondent's financial resources may be relevant to whether he or she should be required to pay for legal representation, but should not govern whether the representation is provided. That a legal services organization or an attorney from a panel of eligible attorneys should be appointed is addressed in Guideline E1.

The National Task Force viewed the availability of an attorney to every civil commitment respondent as essential to the basic fairness of the commitment process. Appointing an attorney for every respondent, without regard to financial need, ensures that a respondent financially capable of employing an attorney, but mentally incapable of intelligently deciding whether to employ one, will be provided the protection needed, given the threat that civil commitment poses to the respondent's personal liberty.[5] In addition to providing legal protection to a respondent, an attorney also can advise his or her client regarding the various options open to the client.[6] Furthermore, appointing an attorney for every respondent facilitates the appointment process by eliminating the need for a preliminary indigency determination, which can delay the appointment. As paragraph (e) of the guideline suggests, a financially capable respondent later may be required to reimburse the reasonable cost of the legal representation.[7]

The guideline recognizes two situations in which appointing an attorney may be unnecessary. First, an attorney should not be appointed if a respondent has retained an attorney. Likewise, if a respondent retains an attorney after one has been appointed, the appointed attorney should be relieved.[8] As a matter of statutory law in some states, respondents have a right to counsel of their own choosing.[9] Second, if, as in most states,[10] the law of the jurisdiction permits a respondent to waive the right to counsel, the court should accept an express, knowing, and intelligent waiver, but should have an attorney stand by to assist the respondent if warranted. Although a respondent should have the opportunity to secure the assistance of an attorney, an attorney generally should not be forced upon a respondent who wishes to represent himself or herself.11 A waiver should not be accepted lightly, however. To ensure that a respondent's wish to waive the assistance of an attorney results from a reasoned choice based on knowledge of the right to counsel and of what the assistance of counsel entails, the guideline requires a judge to find that the waiver has been made clearly, knowingly, and intelligently. A knowing and intelligent waiver is required as a matter of federal constitutional law in criminal cases.[12] Of the six states that have involuntary civil commitment statutes that address the waiver issue, two require a clear, knowing, and intelligent waiver[13] and the rest require similar checks on unwarranted waivers.[14] In requiring that an attorney stand by to assist the respondent if the respondent requests help or if the court determines that an attorney is necessary, the guideline follows the practice in Illinois and Minnesota.[15]

Paragraph (a) of the guideline states that an attorney should be appointed as early in the commitment process as possible. The appointment should occur early in the commitment process not merely to allow the attorney adequate time to prepare for the hearing but also to ensure that a respondent's interests are protected in the prehearing period.[16] Most states' statutes require appointment at the initiation of commitment proceedings,[17] although some permit appointment at a later time[18] or fail to specify when the appointment should occur.[19] The guideline can and should be followed under any of these statutory formulations.

Paragraph (b) provides that an independent third party, such as a local bar association, control the appointment of attorneys. This procedure ensures the attorney's autonomy and avoids undue deference being paid to a

judge's or referee's particular views concerning procedure, preparation, and disposition.[20] Attorneys should be sure who their clients are and should not be beholden to the judge or the court who selected them.

Paragraph (c) of the guideline provides that private attorneys appointed to represent respondents should be paid a reasonable hourly rate for time reasonably spent working on civil commitment cases.[21] The fees typically paid to attorneys in civil commitment cases are too low to encourage effective representation,[22] indicating a lack of understanding of the true role of counsel in these cases.[23]

Paying appointed attorneys low fees, whether as flat fees or by placing a ceiling on pay, diminishes the quality of the representation provided. The problems of jurisdictions providing low-paid court appointments are inherent.[24] The payment scheme most likely to ensure meaningful representation would compensate attorneys by the hour, not by the case,25 at a reasonable hourly rate, that is, a rate consistent with the average community rate for legal services requiring comparable levels of expertise and effort.[26] Because the compensation schemes enunciated in most civil commitment statutes are open-ended,[27] this payment scheme can be implemented without legislation.[28]

Notes

1. *E.g.*, Ala. Code § 22-52-4(a) (1984); Colo. Rev. Stat. § 27-10-107(5) (1982); Fla. Stat. Ann. § 394.467(3)(a) (West Supp. 1985); Iowa Code Ann. § 229.8.1 (West 1985); N.C. Gen. Stat. § 122C-270(a) (Supp. 1985).

2. *E.g.*, Ala. Code § 22-52-4(a) (1984).

3. *E.g.*, Wash. Rev. Code Ann. § 71.05.300 (Supp. 1985); N.C. Gen. Stat. § 122-58.7(c) (1981).

4. Ill. Ann. Stat. ch. 91 1/2, § 3-805 (Smith-Hurd Supp. 1985); La. Rev. Stat. Ann. § 28:55(B) & (C) (West Supp. 1985); Minn. Stat. Ann. § 253B.03(9) (West 1982); Miss. Code Ann. § 41-21-67(3) (Supp. 1985); Mont. Code Ann. § 53-21-116 (1984); S.D. Codified Laws Ann. § 27A-9-8 (1984); Utah Code Ann. § 64-7-36(9) (Supp. 1983); Wyo. Stat. § 25-10-109(h) (1982). *See infra* notes 16-18 and accompanying text for a discussion of the timing of the appointment of counsel.

5. *See Humphrey v. Cady*, 405 U.S. 504, 509 (1972) (recognizing the "massive curtailment of liberty" that involuntary civil commitment entails).

6. *See* Guideline E2, which addresses the attorney's role as advocate and advisor.

7. Implicit in the provision that reimbursement might be required from a financially capable respondent is the assumption that if he or she had been mentally capable of intelligently deciding whether to retain counsel, he or she would have done so. Of the seven state statutes that do not condition the appointment of counsel on the respondent's indigency, *see supra* note 4, only two — Louisiana and South Dakota — provide for reimbursement from financially able respondents. *See* La. Rev. Stat. Ann. § 28:55(B) (West Supp. 1985); S.D. Codified Laws Ann. § 27A-9-15 (1984).

8. *See, e.g.*, Kan. Stat. Ann. § 59-2914(c) (1983); Mich. Comp. Laws Ann. § 330.1454(4) (West Supp. 1985); Okla. Stat. Ann. tit. 43A, § 54.4.D (Supp. 1985).

9. *See* Kan. Stat. Ann. § 59-2914(c) (1983); Md. Health-Gen. Code Ann. § 10-631(a)(2) (1982); Mich. Comp. Laws Ann. § 330.1454(4) (West Supp. 1985); Mo. Ann. Stat. § 632.325(4) (Vernon Supp. 1986); Mont. Code Ann. § 53-21-117 (1984); Nev. Rev. Stat. § 433A.270.1 (1983); Ohio Rev. Code Ann. § 5122.05(C)(2), 5122.15(A)(4) (Page 1981 & Supp. 1984); Okla. Stat. Ann. tit. 43A, § 54.4.D (Supp. 1985); Va. Code § 37.1-65.3(B) (1984).

10. At least two states prohibit the waiver of respondents' counsel in involuntary civil commitment cases. See N.M. Stat. Ann. § 43-1-4.A (1984); S.D. Codified Laws Ann. § 27A-9-8 (1984); *see also Dooling v. Overholser*, 243 F.2d 825 (D.C. Cir. 1957).

11. *Cf. Faretta v. California*, 422 U.S. 806, 820 (1974) (stating that "counsel, like the other defense tools guaranteed . . . shall be an aid to a willing [criminal] defendant — not an organ of the State interposed between an unwilling defendant and his right to defend himself personally").

12. *See Johnson v. Zerbst*, 304 U.S. 458 (1938); *see also* American Bar Association Standing Committee on Association Standards for Criminal Justice, Proposed Criminal Justice Mental Health Standards, Standard 7-5.3 (1984) (hereinafter cited as ABA).

13. Colo. Rev. Stat. § 27-10-107(5) (1982); Or. Rev. Stat. § 426.100(2) (1985). *See also Doremus v. Farrell*, 407 F. Supp. 509 (D. Neb. 1975); *McDuffie v. Berzzarins*, 43 Ohio St. 2d 23, 330 N.E.2d 667 (1975).

14. Conn. Gen. Stat. Ann. § 17-178(b) (West Supp. 1985) (court shall accept respondent's refusal of appointed counsel only if it finds that respondent understands the nature of his or her refusal); Mich. Comp. Laws Ann. § 330.1454(3) (West Supp. 1985) (waiver only after respondent has consulted with appointed counsel and has notified the court in writing); N.H. Rev. Stat. Ann. § 135-B:5 (1977) (requires informed decision to waive counsel); N.D. Cent. Code § 25-03.1-13.3 (Supp. 1985) (waiver only after respondent has consulted with appointed counsel and has notified the court in writing).

15. *See, e.g., In re Tuntland*, 71 Ill. App. 3d 523, __, 390 N.E. 2d 11, 15 (1979); Van Duizend & Zimmerman, *The Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, 33 De Paul L. Rev. 225, 251 (1984). Cf. ABA, *supra* note 12, at Standard 7-5.3(d)(i) (court should consider standby counsel for criminal defendants who proceed *pro se*).

16. *See* Guideline E5, "Prehearing Duties of Respondents' Attorneys"; *see also* La. Rev. Stat. Ann. § 28:55.C (West Supp. 1985), which requires the appointment of counsel as early as possible in every proceeding.

17. These statutes generally require appointment upon the filing of a petition or application for commitment. *See, e.g.*, Ark. Stat. Ann. § 59-1408(b) (Supp. 1985); Minn. Stat. Ann. § 253B.03(9) (West 1982); Okla. Stat. Ann. tit. 43A, § 54.4.C (West Supp. 1985).

18. *See, e.g.*, Ariz. Rev. Stat. Ann. § 36-536.A (Supp. 1985) (at least three days before hearing); N.D. Cent. Code §25-03.1-13.2 (Supp. 1985) (within seventy-two hours, excluding weekends and holidays, of the time the petition was served); S.C. Code Ann. §§44-17-410(3), 44-17-530 (Law. Co-op. 1985) (excluding Saturdays, Sundays, and legal holidays, within five days of emergency admission or within three days of petition); Miss. Code Ann. §41-21-67(3) (Supp. 1985)(counsel appointed at the time the examiners are appointed).

19. *See, e.g.*, Mass. Gen. Laws Ann. ch. 123, § 5 (West Supp. 1985); Mont. Code Ann. §53-21-116 (1983).

20. *See* Stier & Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 Iowa L. Rev. 1284, 1391, 1420 (1979) (finding that many attorneys are "overly deferential" to the court's attitude concerning procedure, case preparation and disposition); Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 Calif. L. Rev. 816, 829-30 (1974) (noting that the court may have a negative influence on legal representation).

21. The guideline presumes that attorneys of legal services organizations receive fixed salaries for their services.

22. *See* D. Wexler, *Mental Health Law: Major Issues*, 98 (1981); Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 Miss. L.J.

43,72 (1974); Dix, *Acute Psychiatric Hospitalization of the Mentally Ill in the Metropolis: An Empirical Study*, 1968 Wash. U.L.Q. 485, 543-45; Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C.L. Rev. 1027, 1048 (1982); Stier & Stoebe, *supra* note 20, at 1393-95.

23. A study conducted in the early 1970s illustrates this continuing problem:

> [C]ompensation for appointed counsel in Arizona is so grossly inadequate that attorneys are unquestionably discouraged from investigating facts, preparing a defense, exploring possible alternatives to commitment, and seeking outside psychiatric opinions. For example, Maricopa County allows $10 per case. Pima County, which previously allowed $5 per case, now uses the services of the public defender. Significantly, some states have begun to recognize that patients at commitment hearings deserve to receive effective representation, and that quality services are far more readily obtained when attorneys are compensated adequately.

D. Wexler, *supra* note 22, at 98 (footnote omitted). The data from the study indicated that attorneys failed to explore even the most elementary legal questions.

Another study, conducted in Iowa in 1979, said that the inadequate preparation of respondents' attorneys can be largely attributed to low attorney fees. Stier & Stoebe, supra note 20, at 1393. According to this study:

> Limited compensation contributes to less effective representation both by failing to offer compensation sufficient to interest more experienced attorneys and by limiting the willingness of counsel to mount an extensive defense. In most counties, there appears to be an informal understanding that bills submitted by appointed counsel will not exceed a set sum, usually an amount less than $100. One referee said that in the absence of unusual circumstances, he refuses to approve any fee covering more than three hours. Many of the referees routinely allow bills of less than three hours, but closely scrutinize bills covering a greater time and frequently reduce them. Several referees said that their county supervisors had informally told them to keep attorneys' fees to a minimum. Thus, an artificial limit is set on the preparation that an attorney will undertake unless the attorney is willing to work without compensation or is willing to attempt to justify payment that exceeds the accepted amount.

Id. at 1393-94 (footnotes omitted). The data indicated that eighty-two percent of respondents' attorneys spent less than two hours on each commitment case, about one hour of which was spent in the commitment hearing. *Id*. at 1394. The remaining hour generally was insufficient to permit adequate reviews of commitment documents, interviews with the respondent and witnesses, and planning of defense strategy. *Id*. at 1394-95.

24. Andalman & Chambers, *supra* note 22, at 72.

25. D. Wexler, *supra* note 22, at 98 ("When counsel is compensated a certain amount per client, he may not have as much incentive to labor over the case as he would if his compensation were tied to time expended in preparation.").

26. *See generally* Hiday, *supra* note 22, at 1048 (appointed attorneys are unlikely to increase their efforts without greater reimbursement for their efforts); Stier & Stoebe, *supra* note 20, at 1423 (compensation rates in Iowa civil commitment cases lag behind rates in other types of cases.)

27. *See, e.g*., Colo. Rev. Stat. ?? 27-10-127 (1982); Conn. Gen. Stat. Ann. § 17-178(b) (West Supp. 1985); Mich. Comp. Laws Ann. § 330.1454(5) (West Supp. 1985); Okla. Stat. Ann. tit. 43A, § 54.4.E (West Supp. 1985); La. Rev. Stat. Ann. § 28:55.B (West Supp. 1985); Utah Code Ann. § 64-7-36(9) (Supp. 1983).

28. *But see* Ark. Stat. Ann. § 59-1408(b) (Supp. 1985) (fee shall not exceed $150); Ill. Ann. Stat. ch. 91 1/2, § 8-22.1(c) (Smith-Hurd 1966) (fee shall not exceed $75 if no jury or $150 with jury). Even in these states the guideline should be followed to the extent permitted by law.

E5. Prehearing Duties of Respondents' Attorneys

To meet his or her obligation to be an advocate and advisor to a respondent during the prehearing period, an attorney should become thoroughly familiar with the respondent's case as soon as possible. The attorney should promptly interview the respondent and provide him or her with necessary advice, review the available records germane to the case, interview witnesses, explore alternatives to commitment, and, if appropriate, negotiate with the state's attorney and with mental health professionals to reach a settlement of the case.

(a) An attorney should familiarize himself or herself with the facts and circumstances of the case and elicit the respondent's views on those facts and circumstances.

Upon being appointed or retained to represent a respondent, an attorney should meet with the respondent as soon as possible. This meeting should be conducted in private and should be held sufficiently before any scheduled hearings to permit effective preparation and prehearing assistance to the client. When meeting with the respondent for the first time, an attorney should identify himself or herself by name and by affiliation, if appropriate. If the first meeting takes place in a mental health facility, the attorney should make it clear to the respondent that he or she is not a member of the facility staff. Importantly, the attorney should inform the respondent that their conversation is confidential.

(i) During the conference, the attorney should obtain the respondent's version of the facts of the case, including

(1) the circumstances surrounding the filing of a commitment petition or emergency detention;

(2) the names, addresses, and telephone numbers of all persons with knowledge of the circumstances surrounding the commitment petition or emergency detention;

(3) any information about past psychiatric hospitalization and treatment;

(4) information to aid the exploration of alternatives to commitment, (e.g., the respondent's ability to care for his or her basic needs if he or she were discharged immediately); and

(5) the names of psychiatrists, psychologists, social workers, and other professionals who examined or treated the respondent during the civil commitment proceedings.

(ii) During the conference, the attorney also should

(1) explain to the client what is happening and why, including the basis on which the respondent's civil commitment is sought and a description of the psychiatric examination and judicial hearing procedures;

(2) explain the client's rights in the commitment process, including the right to treatment and the right to refuse treatment as set forth by the jurisdiction;

(3) if appointed, explain that the respondent may retain his or her own counsel at his or her own expense, rather than accept representation by the appointed attorney, and, if applicable, explain to the person that he or she may be required to reimburse the cost of representation by the appointed attorney;

(4) explain the respondent's right or option to accept voluntary treatment, the procedures for exercising that right, and the legal consequences of voluntary admission to the hospital and discuss whether the client is willing to accept voluntary treatment in the hospital or other settings;

(5) if the respondent is willing and able to give informed consent to voluntary mental health care or related social services as an alternative to civil commitment, obtain his or her consent to enter into negotiations for settlement of the case with the state's attorney and with mental health professionals (as discussed in Guideline D7 and subsections (d) and (e) below);

(6) if a hearing to challenge the civil commitment is not mandatory in the jurisdiction, discuss the desirability of a court hearing with the respondent and, if appropriate, request that he or she sign any document necessary to request a hearing, unless the attorney is authorized by law to request a hearing on the respondent's behalf; and

(7) request the respondent's written or oral permission to obtain access to relevant records.

(iii) In addition to gathering facts and explaining relevant aspects of the commitment proceedings, the attorney should elicit the respondent's views of the facts and circumstances of the case and, importantly, his or her wishes or preferences regarding the preparation of the case.

(b) Sufficiently before the hearing to allow time to investigate the underlying facts and the availability and appropriateness of alternatives to commitment, an attorney should review the relevant petition for commitment, detention order, or other documents used to initiate the commitment proceedings, the screening report, the prehearing examination reports, and the medical records of the respondent.

(c) An attorney should attempt to interview all persons who have knowledge of the circumstances surrounding the commitment petition or emergency detention: the petitioners; the police officers who detained the client; the mental health screening officer; the psychiatrists, social workers, and other persons who have examined or treated the client during the current civil commitment proceedings; the client's family or acquaintances; and any persons who may provide relevant information or who may be supporting or adverse witnesses at a commitment hearing.

(d) If needed, the attorney should secure an examination of the respondent by an independent, impartial mental health examiner, especially in jurisdictions that provide for such an examination at state expense.

(e) If the client has consented to the attorney entering into negotiations with the state's attorney and mental health professionals or presenting evidence of alternatives, as discussed in subsection (a)(ii)(5) above, the attorney should investigate and consider all alternatives to commitment. In conducting this investigation, the attorney should consult with any mental health professionals having information regarding the client, such as a social worker or the mental health screening officer.

(f) As provided in Guideline D7, whenever a respondent has consented to his or her attorney entering into negotiations with the state's attorney and with mental health professionals regarding voluntary alternatives to commitment, the attorney should enter into negotiations using the information obtained through his or her investigation.

Commentary

The prehearing services of an attorney are an indispensable prerequisite for protecting a respondent's interests.[1] No tradition exists, however, in the area of civil commitment to guide attorneys in providing effective representation during the prehearing phase of involuntary civil commitment.[2] The guideline sets forth specific prehearing duties of respondents' counsel that the National Task Force views as necessary for an attorney to fulfill his or her role as advocate and advisor during the prehearing period.

That the duties incumbent upon respondents' attorneys generally are not well understood and that civil commitment cases present special challenges to attorneys is evidenced by the unusual step taken in several states of articulating in statute minimum duties of respondents' attorneys in civil commitment proceedings.[3] For example, in Arizona, within twenty-four hours of appointment, a respondent's attorney must interview the respondent and explain the respondent's rights pending commitment, the commitment procedures and standards, and the alternative of becoming a voluntary patient.[4] At least twenty-four hours before the hearing, the attorney must review the petition for evaluation, the prepetition screening report, and the list of alternatives to commitment; interview the petitioner (if available), the petitioner's supporting witnesses (if known and available), and the physicians who will testify at the hearing (if available); and investigate the possibility of alternatives to commitment.[5] An attorney who fails to fulfill at least these duties may be punished for contempt of court.[6]

Commentators and researchers have decried the performances of many respondents' attorneys and have articulated their views of the requisites of effective representation.[7] Reference to these authorities can provide helpful instruction to attorneys who represent respondents. Guideline E5 synthesizes the essentials of effective representation during the prehearing period. Though much of the guideline needs no further explanation, a few aspects bear some discussion.

Paragraph (e) of this guideline requires attorneys to explore appropriate alternatives to involuntary commitment. Under ideal conditions, the screening conducted by a mental health screening officer[8] or the prehearing examination[9] performed shortly after a respondent has been presented to a mental health facility should include a full exploration of alternatives and a determination of whether the respondent's needs can best be met by some intervention other than compulsory treatment and care. Although attorneys should study the screening application,[10] the screening report,[11] and the prehearing examination report,[12] if available, and consult with the mental health screening officer, an independent mental health examiner, and facility staff about alternatives, conditions are seldom ideal, and the attorney should not place total reliance on those reports. A respondent's condition at the time of the attorney's contact may be different than it was during previous contacts with law enforcement officers and mental health professionals. Improvement in the respondent's condition may open up previously unavailable options. Attorneys should determine the range of current, appropriate alternatives available to the client. Such determination requires not only a knowledge of the law and the facts of the case but also a working familiarity with the continuum of services[13] available in the community. Consistent with the role of an attorney as an advocate and advisor, the attorney should discuss with the respondent all alternatives and options, but never recommend a particular option or alternative as "needed." The attorney's preferences should only be discussed in light of the chances of particular options or alternatives prevailing in the case.[14]

Notes

1. Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 Calif. L. Rev. 816, 829 (1974).

2. Andalman & Chambers, *Effective Counsel for Persons Facing Civil Commitment: A Survey, a Polemic, and a Proposal*, 45 Miss. L.J. 43, 84 (1974); Committee on Mentally Disabled of the State Bar of Michigan, *Guidelines for Defense Counsel in Commitment Cases*, 59 Mich. B. J. 709, 709 (1980) (hereinafter cited as Committee).

3. A few states have detailed provisions regarding counsel's duties. *See* Ariz. Rev. Stat. Ann. §36-537 (Supp. 1985); Minn. Stat. Ann. §253B.03 (9) (West 1982); Miss. Code Ann. §41-21-102(8) (Supp. 1985); Tex. Rev. Civ. Stat. Ann. art. 5547-45 (Vernon Supp. 1986); W. Va. Code §27-5-4(h) (Supp. 1985). Some other states have more limited provisions regarding counsel's duties. *See* Cal. Welf. & Inst. Code §5302 (West 1984) (in a postcertification proceeding, the attorney shall advise the respondent of his or her rights in the proceeding and represent him or her before the court); Iowa Code Ann. §229.9 (West 1985) (the attorney shall represent the respondent at all stages of the proceedings and attend the hospitalization hearing); Mich. Comp. Laws Ann. §330.1454(7) (West Supp. 1985) (counsel shall consult with the respondent at least twenty-four hours before hearing and file with the court a certificate stating that he or she has done so); Okla. Stat. Ann. tit. 43A, §54.4.D (West Supp. 1985) (the attorney shall meet and consult with the respondent within one day of notification of his or her appointment and immediately upon meeting with the respondent present the respondent with a statement of his or her rights); Or. Rev. Stat. §426.100(3) (1983) (in all suitable cases, counsel shall be present at the hearing and examination); *see also* Minn. R. Commitment Act 4 (1985), where the Minnesota Rules of Court elaborates on the duties of respondents' attorneys as prescribed in that state's statutes.

4. Ariz. Rev. Stat. Ann. §36-537.B.1 (Supp. 1985).

5. *Id.* §36-537.B.2, -.3, -.4.

6. *Id.* §36-537.

7. *See, e.g.*, D. Wexler, *Mental Health Law: Major Issues* 98-101 (1981); Andalman & Chambers, *supra* note 2, at 50-74, 84-85, 89-90; Cohen, *The Function of the Attorney and the Commitment of the Mentally Ill*, 44 Tex. L. Rev. 424 (1966); Committee, *supra* note 2; Hiday, *The Attorney's Role in Involuntary Civil Commitment*, 60 N.C.L. Rev. 1027 (1982); Lockwood, *How to Represent a Client Facing Civil Commitment*, 26 Prac. Law. 51 (1980); Mutnick & Lazar, *A Practical Guide to Involuntary Commitment Proceedings*, 11 Willamette L.J. 315, 318-35 (1975); Perlin, *Representing Individuals in the Commitment and Guardianship Process*, in P. R. Friedman, 1 Legal Rights of Mentally Disabled Persons, at 497, 507-15 (1979); Perlin & Sadoff, *Ethical Issues in the Representation of Individuals in the Commitment Process*, 45 Law & Contemp. Probs. 161, 164-73 (Summer, 1982); *Practice Manual: Preparation and Trial of a Civil Commitment Case*, 5 Mental Disability L. Rep. 201, 201-10, 281-95, 358-62 (1981); Special Project,

The Administration of Psychiatric Justice: Theory and Practice in Arizona, 13 Ariz. L. Rev. 1, 56-60 (1971); Stefan, *Right to Counsel in Civil Commitment Proceedings*, 9 Mental & Physical Disability L. Rep. 230, 233 (1985); Note, *The Right to Counsel at Civil Competency Proceedings*, 40 Temp. L. Q. 381, 387-89 (1967).

8. *See* Guideline B6, "Screening by a Mental Health Screening Officer."

9. *See* Guideline D4, "Prehearing Examination Procedures."

10. *See* Guideline B4, "Application for Screening."

11. *See* Guideline B7, "Screening Report."

12. *See* Guideline D5, "Prehearing Examination Reports."

13. *See* Guideline A2, "Continuum of Services; Directory."

14. A member of the National Task Force recommended that respondents be counseled as follows:

> You're the boss! I am here to try to get for you whatever it is you want out of this proceeding. If you want to stay here in the hospital, I'll try to make that possible so that you won't have to be committed. If you want out, I'll try to get that for you. You're in charge. What you say goes! I'll advise you about all of your options, and I may counsel you to choose a particular option because I think that it might have the greatest chance of success. But in the end, it's your decision, because it's your life!

E6. Availability of Records

Effective legal representation of a respondent requires that the respondent's attorney have free and immediate access to all pertinent documents, including, but not limited to, the commitment petition, the detention order, the police report, other documents used to initiate commitment proceedings, the screening report, the prehearing examination reports, and the medical records of the respondent. Because hearings in civil commitment cases occur much sooner than hearings in most civil cases, discovery should be expedited and not be impeded by restrictive procedures and time limits that generally apply in civil proceedings.

Commentary

An attorney's ability to prepare a commitment case and to assume his or her proper role as advocate and advisor to the respondent[1] depends upon his or her access to all information relevant to the case. Guideline E6 provides that the respondent's counsel should have timely access to all mental health and medical records, screening reports, examination reports, and court records. Although in practice few hospitals block an attorney's access to hospital records,[2] some state laws extend confidentiality and consent restrictions to attorneys represent-ing respondents.[3]

Notes

1. *See* Guideline E2, "Respondent's Counsel as Advocate and Advisor."

2. A study of legal representation of respondents in Columbus, Ohio, indicated that respondents' attorneys typically review the hospital medical charts prior to interviewing respondents. A hospital medical chart may include the admission record, a voluntary admission form, records of psychiatric examinations, psychiatric histories, medical examinations, treatment plans, and past and present medication. The policy of at least one private facility in Columbus closely tracks Ohio law, providing access to hospital records only upon the written consent of the respondent. This policy has apparently frustrated some attorneys, and some hospital administrators have expressed their own misgivings. The policy of this private facility is in contrast with that of at least one public-sector hospital, where access to respondents' records is unrestricted except in some rare cases in which hospital staff unfamiliar with court-appointed attorneys have resisted attempts to gain access to hospital records. Keilitz & Roach, *A Study of Defense Counsel and the Involuntary Civil Commitment System in Columbus, Ohio*, 13 Cap. U.L. Rev. 175, 184-85 (1983).

3. *E.g.*, Ohio Rev. Code Ann. § 5122.15(A)(1)(b) (Page Supp. 1984)(all relevant hospital records must be made available to counsel with the consent of the respondent); *see also* Utah Code Ann. § 64-7-36(a) (Supp. 1983).

E7. Conversion From Involuntary to Voluntary Patient Status

Generally, voluntary mental health treatment and care is viewed as preferable to coerced intervention, and, accordingly, respondents may elect to become voluntary patients with the encouragement of mental health professionals. Sometimes, however, respondents may be subject to pressure from mental health facility staff to accept voluntary patient status.

(a) In order to ensure that both the election of voluntary patient status and the nature of that status is appropriate and meaningful, the attorney should confer with the respondent to determine that the decision to become a voluntary patient was, in fact, voluntary and that it was made free of coercive influences. The attorney should be required to certify to the court at the hearing that he or she has discussed voluntary admission with the person and that the attorney believes that the person's decision to become a voluntary patient was, in fact, voluntary and was made with knowledge of its legal and treatment consequences.

(b) If the attorney believes that the respondent did not willingly and knowingly convert to voluntary status, the respondent, through his or her attorney, should discuss the conversion to voluntary patient status with facility staff. If the discussion does not lead to a result satisfactory to the respondent, the attorney should take whatever actions necessary.

Commentary

The issue of conversion of respondents from involuntary to voluntary patient status centers on three concerns: (1) the possible coercion of involuntary patients by mental health staff to elect voluntary patient status, (2) abuses of the conversion procedure by involuntary patients unsuitable for voluntary status in order to "sign themselves out" of the hospital, and (3) procedural solutions to these concerns that are so complex or onerous that they are unworkable or place an undue burden on attorneys and mental health personnel. The purpose of Guideline E7 is to provide some assurance, by intervention by the respondent's attorney, that the respondent has had an opportunity to consider the consequences of conversion to voluntary hospitalization, without unnecessarily intruding on the mental health professionals' abilities to provide proper care and treatment and to manage their facilities.

There is an implicit assumption that when persons choose to undergo mental health care and treatment on a voluntary basis, it is not the state that has forced them to seek help. Clearly, voluntary treatment and care is viewed as preferable to involuntary treatment for a number of reasons. A respondent who recognizes the need for treatment and seeks it voluntarily may be more likely to benefit from such treatment. Voluntary patient status generally brings more privileges. Further, by electing voluntary admission before any judicial hearings have occurred, a respondent avoids the stigma of compulsory hospitalization, the commitment case will be dismissed, and in some states all court records will be expunged. Finally, voluntary patient status demands considerably less paperwork and legal involvement for the hospital staff.

However, to protect both the interests of the respondent and the integrity of the system of conversion from involuntary patient status to voluntary status, some mechanism is needed to make certain that the voluntary admission procedure is not being misused.[1] Although it can be argued that the right of a voluntary patient to be released on request vitiates any harm that may result from an uninformed, induced, or incompetent consent, reliance on a procedure that sanctions inappropriate practices would invite abuse and undermine the respect and support of both the legal and the mental health systems. At least three checks on the "voluntariness" of a conversion from involuntary to voluntary admission are possible: (1) relying on respondents to raise objections when they conclude that their rights have been violated, (2) requiring certification and judicial review of every decision by a respondent to become a voluntary patient,[2] and (3) introducing a screening procedure to identify those cases meriting judicial scrutiny.

Guideline E7 endorses the last option as the most expeditious means by which the respondent can be afforded the maximum protection. Guideline E7 places confidence in an attorney's interviewing skills and abilities to interact with mental health professionals to resolve problems informally. The attorney would be required to meet with the respondent to ascertain whether the respondent was indeed aware that by electing to convert to voluntary patient status, he or she was agreeing to enter or remain in the hospital and to ascertain that this agreement was not the product of threats, unrealistic promises, or other forms of coercion. When, due to the respondent's disability, the effect of medication, or other factors, the attorney is unable to determine that the conversion to voluntary patient status was made knowingly and voluntarily, he or she should consult with hospital staff and, if necessary, advise the court. The court should then conduct an inquiry into the matter.

Notes

1. *See* Owens, *When Is a Voluntary Commitment Really Voluntary?*, 47 Am. J. Orthopsychiatry 104 (1977) (providing examples of "dubious" voluntary admissions); Lewis, Goetz, Schoenfeld, Gordon, & Griffin, *The Negotiation of Involuntary Civil Commitment*, 18 L. & Soc'y Rev. 629, 630 (1984) ("Voluntary admissions are in many cases devices that allow authorities to hold patients in the hospital without resorting to the time-consuming process of formal involuntary civil commitment."); Parry, *Summary, Analysis and Commentary*, 9 Mental and Physical Disability L. Rep. 162, 163 (1985) ("Only a judge or jury can determine whether any particular actions taken by hospital staff, or conditions within the institution, by themselves or in combination with other actions or conditions, constitute sufficient negative influences on the patient to legally invalidate the voluntariness or a decision.").

2. This procedure is used in Chicago. *See* Van Duizend & Zimmerman, *The Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, 33 De Paul L. Rev. 225, 243-45 (1984); *see also* Parry, *supra*.note 1.

PART F
COURT HEARINGS

As emphasized in Part B, most involuntary civil commitment cases are screened and diverted to the voluntary mental health care system before any substantial involvement by the courts. The majority of respondents in commitment cases never participate in formal court hearings. For those who do, such hearings are crucial. They are, indeed, the centerpiece or "summit" of the commitment process toward which all prehearing procedures build.[1]

Prompt court hearings on the "committability" of persons detained pursuant to involuntary civil commitment are a part of established law.[2] In formal court hearings the legal process unfolds. State laws and constitutional standards governing involuntary civil commitment are applied, and the respondent, through his or her attorney, has an opportunity to challenge the validity and the strength of the evidence introduced in support of commitment in an adversarial hearing before an impartial fact finder (judge or jury). The fact finder weighs the evidence for and against commitment and examines the competing interests of the respondent, the state, the family, and the community. Finally, a decision disposing a commitment petition is made.[3]

This part contains ten guidelines establishing recommended principles, procedural mechanisms, and practices to govern court hearings, including their timing and location, rights of the respondent during hearings, duties of counsel, role of the presiding judicial officer, applicable legal rules, waiver of jury trials, calling of witnesses, and public access to the hearings. For the sake of clarity of exposition and organization, these guidelines have been grouped under the heading of "court hearings." However, the guidelines and accompanying commentaries have bearing on aspects of the commitment process other than the formal judicial hearing. Similarly, the guidelines in other parts of this guidebook apply to the conduct of court hearings. For example, Guideline E5, "Prehearing Duties of Respondents' Attorneys," has obvious relevance to, and overlaps with, Guideline F5, "Duties of Respondents' Attorneys during Hearings," in this part. The same is true of the relationship between guidelines in this part and most of those in Part G, "Judicial Determinations and Case Dispositions," which focus on the adjudicative and dispositive factors that should be considered by a commitment court. No clear line can be drawn between some of the procedures and practices during court hearings and the substantive findings and deliberations of a court. Although each of the guidelines in Part F stands alone, it is best to read them together with other relevant guidelines throughout this guidebook.

Notes

1. Stier & Stoebe, *Involuntary Hospitalization of the Mentally Ill in Iowa: The Failure of the 1975 Legislation*, 64 Iowa L. Rev. 1284, 1340 (1979).

2. *See Lynch v. Baxley*, 386 F. Supp. 378, 388 (M.D. Ala. 1974), *rev'd on other grounds*, 651 F.2d 387 (5th Cir. 1981) (a hearing must be given within a reasonable time to test whether there is probable cause to believe that confinement is necessary under constitutionally proper standards for commitment); *Logan v. Ar*afeh, 346 F. Supp. 1265, 1268 (D. Conn. 1972), *aff'd sub nom., Briggs v. Arafeh*, 411 U.S. 911 (1973) (emergency commitment "without prior notice and hearing does not offend the due process clause provided [that a hearing is available] within a reasonable period of time"); *Anderson v. Solomon*, 315 F. Supp. 1192, 1194 (D. Md. 1970)("[D]ue process requires that a hearing be held at some reasonable point in time before a person can be indeterminately committed."). Since the United States Supreme Court's decision in *O'Connor v. Donaldson*, 422 U.S. 563 (1975), courts have ruled that an initial hearing must be held within several days after detention. *See, e.g., Doe v. Gallinot*, 486 F. Supp. 983 (C.D. Cal. 1979) (seventeen days is not acceptable; seventy-two hours plus sufficient time to arrange a hearing, for a total of less than seven days, is permissible); *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Hawaii 1976) (a few days); *Doremus v. Farrell*, 407 F. Supp. 509 (D. Neb. 1975) (five days); *Bartley v. Kremens*, 402 F. Supp. 1039 (E.D. Pa. 1975), *vacated and remanded on other grounds*, 431 U.S. 119 (1977) (seventy-two hours); *Lynch v. Baxley*, 386 F. Supp. 378 (M.D. Ala. 1974), *rev'd on other grounds*, 651 F.2d 387 (5th Cir. 1981) (seven days); *Bell v. Wayne County General Hospital*, 384 F. Supp. 1085 (E.D. Mich. 1974) (five days); *Lessard v. Smith*, 349 F. Supp. 1078 (E.D. Wis. 1972), *vacated on other grounds*, 414 U.S. 473 (1974), *on remand*, 379 F. Supp. 1376 (E.D. Wis. 1974), *vacated and remanded*, 421 U.S. 957 (1975) (forty-eight hours); *State ex rel. Doe v. Madonna*, 295 N.W.2d 356 (Minn. 1980) (seventy-two hours).

State statutes impose similar time limits. *See, e.g.*, Md. Health-Gen. Code Ann.§ 10-632 (b), (c) (Supp. 1985) (within five days, or, with good cause shown, may be postponed for up to ten days from respondent's original confinement); N.M. Stat. Ann.§ 43-1-11(a) (1984) (seven days); Ohio Rev. Code Ann. § 5122.141(B)(6) (Page 1981) (three court days, or up to ten court days for good cause shown); Pa. Stat. Ann. tit. 50, § 7304(b)(4) (Purdon Supp. 1985) (five days); Wis. Stat. Ann. § 51.20(7)(a) (West Supp. 1985) (three days, excluding Saturdays, Sundays and legal holidays). *But see* Conn. Gen. Stat. § 17-183 (West Supp. 1985) (up to fifteen days' emergency commitment upon a physician's certificate alone); N.C. Gen. Stat. § 122C-267(a) (Supp. 1985) (ten days); N.Y. Mental Hyg. Law § 9.31(a) (McKinney 1986) (hearing provided only upon the respondent's request).

3. *See generally* R. Reisner, *Law and the Mental Health System* 394-23 (1985); S. Brakel, J. Parry, & B. Wiener, *The Mentally Disabled and the Law* (3rd. ed. 1985).

F1. Timely Scheduling and Notice of Hearings

Notice of the time and place of an involuntary civil commitment hearing should be delivered promptly. Due process requires such fair and timely notice. The purpose of a notice requirement is to advise interested parties of a pending action or proceeding and to provide information and necessary time to permit the parties to prepare themselves and present any possible objections. Without effective

notice, the commitment process is subject to delay and abuse.

(a) The time and place of a hearing should be scheduled no more than one business day after a respondent is taken into custody or a petition for involuntary commitment is filed with the court.

(b) The court should issue notice of the hearing immediately after it has been scheduled. The notice should be delivered by the most expeditious means to all persons with a legitimate interest in the proceedings, including the respondent, a family member or guardian of the respondent, the respondent's attorney, the petitioner and his or her attorney, the attorney representing the state, the director of the facility in which the respondent is detained, the screening agency in the jurisdiction, and anyone designated by the respondent.

(c) In addition to the date, time, and place of the hearing, the notice sent to the respondent and to the petitioner should be accompanied by a copy of the petition and a description of the nature, purpose, and possible consequences of the court hearing. The notice and other information furnished to the respondent and the petitioner should be phrased in clear, nontechnical language.

Commentary

Once it has been determined that a court hearing on commitment will take place, it is imperative that the hearing be scheduled and notice issued and delivered as quickly as possible to permit interested parties to prepare themselves.[1] An expedited procedure should be established and implemented by the administrative judge, the court administrator, or the court clerk for setting a time and date for a court hearing and for issuing notice of the hearing no later than one court day (*viz*., excluding weekends and holidays) after a respondent is detained or a petition for commitment is filed with the court.

Guideline F1 urges that every effort be made to involve respondents in commitment proceedings to the greatest extent and as early as possible, including giving them fair notice of pending actions or proceedings. This should be done despite the facts that some respondents will not be able to comprehend all of the information and that many may not appear receptive to the information.

Although the formal notice of a court hearing should be communicated in writing, key participants who are known to the court and who are familiar with the commitment process, such as the respondent's counsel, the attorney for the state, the director of the facility where a respondent has been detained pending the court hearing, and a mental health screening officer, may be notified in a more expeditious manner, such as by telephone or by personal service.

Guideline F1 recommends that two forms of notice be required. Persons presumed to be familiar with the commitment process need only be advised of the date, time, and place of the hearing. However, the petitioner and the respondent are to be advised of the hearing's purpose and possible consequences (e.g., discharge or treatment including possible hospitalization for a specified period of time). If the respondent has not already received a copy of the petition, a copy should be attached to the hearing notice. Paragraph (c) also urges that the explanation of purpose and possible consequences of the court hearing be presented in lay terms. In accordance with Guideline E5(a)(ii), the respondent's attorney should be obligated to provide an oral explanation of the notice, including the purpose and possible consequences of the hearing and the respondent's rights. When, because of language differences, illness, or disabilities of the respondent, the attorney cannot provide this explanation directly, arrangements should be made to have it presented in the language and mode of communication that the respondent is most likely to understand.

Notes

1. Statutes vary considerably in provisions for whom is to receive notice of the hearing, what the notice should contain, and how it should be presented. Most states provide for notice to be given to the respondent, to a close relative or guardian, and to the individual's attorney(s). Some require that notice be provided to a department of mental health or to the local community mental health facility. *E.g*., W. Va. Code § 27-54(e) (Supp. 1985). A few specify that the petitioner be notified of the hearing. E.g., Ohio Rev. Code Ann. § 5122.12 (Page 1981); Ind. Code Ann. § 16-14-9.1-9(b) (Burns Supp. 1985); Mich. Comp. Laws Ann. § 330.1453(1) (West 1980). Also, some statutes require that notice of the filing of a petition or of a hearing be given to the local prosecutor, e.g., Mich. Comp. Laws Ann. § 330.1453(1) (West 1980), or that notice must be sent to two or three persons named by the respondent or the court, *e.g*., Ill. Ann. Stat. ch. 91 1/2, § 3-706 (Smith-Hurd Supp. 1985); N.Y. Mental Hyg. Law § 9.31(c) (McKinney 1986).

Some statutes require that the petition be attached to the notice. Some add the supporting affidavits of petitioner(s). *See, e.g*., Ariz. Rev. Stat. Ann. § 36-536.A (Supp. 1985). Others specify that the notice include a list of the respondent's rights. See, e.g., Okla. Stat. Ann. tit. 43A, § 54.4.C (West Supp. 1984-85); W. Va. Code § 27-5-4(e) (Supp. 1985). The timing of the notice ranges from fourteen days to forty-eight hours before the hearing. Most statutes fail to address the means for delivering notice in involuntary civil commitment cases. This omission suggests that the methods used to provide notice in civil cases generally apply to commitment proceedings. Few statutes assign responsibility for providing notice. See Wis. Stat. Ann § 51.20(2) (West Supp. 1985) (places responsibility of giving written and oral notice on the officer taking custody of the respondent and on hospital staff); see also In re Gault, 387 U.S. 1, 33 (1967); *Stamus v. Leonhardt*, 414 F. Supp. 439, 446 (S.D. Iowa 1976); *Suzuki v. Quisenberry*, 411 F. Supp. 1113, 1127 (D. Hawaii 1976); *Lynch v. Baxley*, 386 F. Supp. 378, 388 (M.D. Ala. 1974), rev'd on other grounds, 651 F.2d 387 (5th Cir. 1981).

See generally Doremus v. Farrell, 407 F. Supp. 509, 515 (D. Neb. 1975) (notice must include "the time and location of the hearing — the reason for his detention [and] the standards for commitment"); *French v. Blackburn*, 428 F. Supp. 1351, 1356 (M.D.N.C. 1977) (notice should be "reasonably calculated to inform the person to whom it is directed the nature of the proceedings").

F2. Automatic Court Hearings within Three Days

Established law requires that an evidentiary hearing be held within a reasonable period of time after a respondent is admitted and involuntarily detained in a mental health facility or a petition for involuntary civil commitment is filed.

(a) A hearing should be held as soon as possible, but no more than three court days after a respondent has been taken into custody or a petition for involuntary civil commitment has been filed and is pending with the court.

(b) Adjournments should be granted if reasonably requested by the respondent's counsel, but should rarely, if ever, be granted over the respondent's objections.

Commentary

Guideline F2 requires that an evidentiary hearing be held as soon as possible, and in no event, except upon court approval of necessary and proper postponements, more than three days (excluding weekends and holidays) after a respondent is taken into custody or a petition is filed.[1] This guideline is premised on the stringent prehearing screening procedures prescribed by the guidelines in Part B for identifying and diverting most persons who could be adequately served by community mental health facilities or who do not require involuntary mental health services. It is also premised on the availability of properly safeguarded voluntary admission procedures for those able and willing to consent to treatment. In this way, commitment hearings will be limited to those cases in which there is disagreement over the need for involuntary commitment. Given the liberty interests threatened by involuntary commitment, as well as the limited treatment resources available, hearings should be resumed in these relatively few cases. In jurisdictions, such as New York, which do not provide mandatory evidentiary hearings as a matter of statutory law, but make hearings available upon request,[2] the attorney should, with the respondent's consent, request a prompt hearing in accordance with Guideline F2.

State laws use two factors to determine what is a reasonable time period within which to hold a commitment hearing: (1) the time that may elapse prior to a hearing and (2) the event from which this time period is to begin. The triggering event may be the filing of the petition,[3] the act of taking the defendant into custody,[4] or the filing of a request for a hearing.[5]

How much time should elapse before a hearing is required depends on several considerations. The first is the respondent's interest in being quickly released from custody or in having an unsupported petition for commitment dismissed as soon as possible. However, it may be in the best interest of a respondent who is extremely agitated to delay a hearing until he or she is stabilized, to avoid allowing the agitated state of the respondent to sway the court toward commitment. Second, prompt hearings may also serve to reduce opportunities for undue, intense institutional pressures on a respondent to convert to voluntary patient status (see Guideline E7). Third, there is a countervailing need to provide sufficient time for the respondent to be properly examined and for each side in the proceeding to adequately prepare its case. Indeed, the few cases that come before a court in a formal evidentiary hearing are those that demand the greatest amount of preparation by the attorneys (see Part E, "Legal Representation"). Fourth, if prehearing treatment is delayed,[6] there is the additional concern of authorizing needed treatment expeditiously. Finally, when prehearing treatment is provided, there is the countervailing consideration of giving the respondent an opportunity to recover without incurring a record of an involuntary commitment.

Automatic court hearings held within three days after a respondent is taken into custody or after a petition is filed provide a good balance between the need to curtail unwarranted actions taken against the respondent and the need for sufficient time to permit the parties to prepare themselves and present their cases. Courts are encouraged to hold commitment hearings within this time period, even though many state statutes governing the conduct of commitment hearings may be more permissive.

Care should be taken to assure that the opportunity for adjournment of the court hearing provided by paragraph (b) of the guideline is not misused.[7] A respondent, through his or her attorney, may seek to postpone the hearing for a number of reasons: (a) to arrange for an independent examination, (b) to arrange for voluntary treatment alternatives, (c) to secure the presence of a particular witness, (d) to recover from a physical illness, and (e) to recover sufficiently from the mental illness to obviate the need for involuntary commitment. Because the likelihood is slight that respondents in custody will abuse the availability of adjournments, hearing postponements sought or stipulated by respondents should ordinarily be granted. Because of the strong public interest in prompt determinations of cases, as well as the burden imposed on the respondent by delay, adjournments should not be granted if the respondent objects.

Guideline F2 does not require a preliminary or probable cause hearing held prior to a recommended "full" evidentiary or adjudicatory hearing within three court days.[8] There are several reasons for this. First, hearings are costly and time-consuming for all concerned. In jurisdictions requiring a preliminary hearing after a few days, followed by a "full" hearing,[9] double appearances by lawyers, court personnel, and witnesses place a considerable strain on the system, with dubious advantages to the respondent.[10] Second, a full evidentiary hearing within three days obviates the need for a probable cause hearing within that time period. Indeed, the three-day time limit imposed by Guideline F2 to test whether commitment

criteria are satisfied comports with the time standard for probable cause determinations in an informal, preliminary hearing recommended by the American Psychiatric Association.[11] Finally, prehearing screening prescribed by the guidelines in Part B should effectively divert from involuntary detention all respondents whose cases are unlikely to satisfy commitment criteria.

Notes

1. For a review of selected statutory provisions and relevant case law, see Guideline F1 at note 1.

2. N.Y. Mental Hyg. Law § 9.31(a) (McKinney 1986).

3. *See, e.g.*, Ariz. Rev. Stat. Ann. § 36-535.B (Supp. 1985).

4. E.g., N.C. Gen. Stat. § 122C-267(a) (Supp. 1985).

5. *E.g.*, N.Y. Mental Hyg. Law § 9.31(a) (McKinney 1986).

6. *See* Guideline D6, "Prehearing Mental Health Treatment."

7. *See* Lewis, Goetz, Schoenfield, Gordon & Griffin, *The Negotiation of Involuntary Civil Commitment*, 18 L. & Soc'y Rev. 629, 641- 44 (1984).

8. *See* Minn. Stat. Ann. § 253B.07(7) (West Supp. 1986); Cal. Welf. & Inst. Code § 5254 (West 1984); Ohio Rev. Code Ann. §5122.141 (Page 1981); Va. Code § 37.1-67.1 (1984).

9. *E.g.*, Wis. Stat. Ann. § 51.20(7) & (10) (West Supp. 1985); Ohio Rev. Code. Ann. §§ 5122.14, .15 (Page 1981 & Supp. 1985).

10. *See* I. Keilitz, *Involuntary Civil Commitment in Columbus, Ohio* 73-77, 84-86 (1982) (noting that the outcome of "full" hearings in Columbus rarely ever is different from that of the probable cause hearing); *see also* I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 83-86 (1983).

11. American Psychiatric Association, *Guidelines for Legislation on Psychiatric Hospitalization of Adults*, Guideline 4.F., in American Bar Association, Issues in *Forensic Psychiatry* 38 (1984).

> Each person who is admitted to a treatment facility shall receive a preliminary hearing within five business days of admission or be discharged, unless he has, after consultation with counsel, executed a written waiver of such hearing. The hearing shall be informal and subject to such rules as the Court sets consistent with fundamental fairness.

Id.

F3. Location of Hearings

The setting in which a hearing is held should befit the seriousness of the issues to be addressed. Hearings should be conducted in a regular courtroom or, alternatively, in a room at a mental health facility which is of adequate size and decorum, with sufficient dignity to elicit the customary respect afforded court proceedings.

Commentary

For judges, attorneys, and court personnel, the most convenient setting for commitment hearings is likely to be a courthouse. In contrast, psychiatrists, psychologists, and other hospital staff benefit from having the hearings at the hospital. Doctors and other professional staff may dislike traveling to a courtroom, waiting for judges to arrive, waiting for their case to be called, and possibly doing this to no avail if a continuance is ordered. The intrusion on treatment staff time is less if hearings are held within their treatment facility. Like the decision regarding the timing of the hearing, selecting a hearing site requires a balancing of conflicting interests.[1]

Hearings held at a mental health facility limit the logistical problems and inconvenience of transporting respondents to the courthouse and attending to them, if necessary, once in the courthouse. It facilitates the attendance of psychiatrists and hospital staff at the hearing. To some extent, it minimizes both the apprehension and the discomfort of respondents. If the hearing is held at the facility, respondents are spared the possible intimidation of supervised transportation to, and confinement in, the courthouse, as well as the accompanying indignities and discomforts of such arrangements. In a mental health facility, a respondent may await the start of his or her hearing in the relative comfort of a patient room or dayroom which may compare quite favorably with a "holding cell" of a courthouse. Because treatment staff do not regularly attend hearings in jurisdictions that hold commitment hearings in a courthouse, the respondent's opportunity to confront and cross-examine key witnesses is enhanced by holding the hearing at the hospital.

Nevertheless, a hearing in a hospital may appear confusingly like a treatment conference unless care is taken to assure that judicial decorum is maintained both in the setting and in the conduct of the hearing. Some facilities tend to discharge cases in order to avoid sending staff and patients to hearings at the courthouse.[2]

When hearings are held in a courtroom, the paramount concerns should be risk to the respondent and inconvenience to the court and hospital staff. When hearings are held in the hospital, care should be taken to assure that the setting for the hearing maintains the dignity and formality of a courtroom.[3] The dignity of the court, however, should not be compromised for the sake of convenience. Following the Massachusetts Standards of Judicial Practice for Civil Commitment Proceedings, this guideline urges that the setting befit the seriousness of a proceeding in which an individual's liberty is at issue. As stated in commentary to the Massachusetts standards:

> Judges should wear robes and the hearing room should, at a minimum, contain an appropriate area for the Judge, counsel, the respondent and witnesses to sit. The hearing room should, whenever possible, contain those furnishings normally found in a courtroom. The purpose of such formality is not to inhibit or intimidate a respondent, but rather to remind all parties that a formal court proceeding has commenced. . . . Informal physical settings in commitment hearings, where they have been allowed to exist, have often appeared to foster other procedural informalities which would be clearly unacceptable in most court proceedings.[4]

Notes

1. Those statutes which address the issue generally provide some flexibility concerning the location of the hearing. *E.g.*, Va. Code § 37.1-67.4 (1984) (hearings may be conducted at a convenient institution or other place). Hearings may be held in a courtroom, in the judge's chambers, or at a mental health facility. Some also permit the hearing to be held at the respondent's home or another suitable place not likely to have a harmful effect on the person's health or well-being. *See, e.g.*, Idaho Code § 66-329(h) (Supp. 1985); Ind. Code Ann. §§ 16-14-9.1-9(b), -9.1-10(c) (Burns Supp. 1985). Others prohibit holding the hearing in a regular courtroom if the respondent objects and a more suitable place is available. *See, e.g.*, N.C. Gen. Stat. § 122C-267(f) (1985).

2. In some metropolitan areas, like Los Angeles, where commitment hearings are held in a centralized court facility, respondents must travel many miles between the mental health facility and the court facility, often necessitating their beginning the day at a very early hour and taking very long bus trips to reach the court facility in time for the hearing. *See* Keilitz, Fitch, & McGraw, *A Study of Involuntary Civil Commitment in Los Angeles County*, 14 Sw. U.L. Rev. 238 (1984). *See generally*, C. Warren, *The Court of Last Resort: Mental Illness and the Law* (1982).

3. Wisconsin law authorizes court hearings to be held at the institution where the respondent is hospitalized unless the respondent or his or her counsel objects. Wis. Stat. Ann. § 51.20(5) (West Supp. 1985).

> [P]robable cause hearings in Milwaukee County are generally held in Ward 53B. Final commitment hearings, on the other hand, are held in Room 1032 of the Milwaukee County Mental Health Complex. Room 1032 provides a relatively formal setting appropriate for the solemnity of the final hearing process. At the front of the room is a table at which the presiding judge sits. Testifying witnesses sit to the judge's left and the court reporter, against the side wall. Near the front on opposite sides of the aisle are tables for corporation counsel and for the respondent and his or her counsel. Near the back door is a table for the Mental Health Complex court liaison officer, who functions as bailiff. On either side of the aisle are rows of chairs for other participants and observers.

I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 87 (1983) (citation omitted).

4. *Massachusetts Standards of Judicial Practice: Civil Commitment*, Standard 2:00 (1979) (emphasis in original). *Cf.* Recommendation 17 of the Minnesota Supreme Court Study Commission on the Mentally Disabled & the Courts:

> Because a proposed patient will benefit from an awareness of the seriousness of the process, and will be helped, not harmed, by a full, thorough hearing which airs the reasons for commitment, and to separate the commitment process from the treatment process, it is recommended that the hearing take place in court, not in a hospital or chambers, absent a request by the proposed patient or a specific finding of necessity by the court.

Civil Commitment in Minnesota: Final Report 80 (1979).

F4. Presiding Officers

The individuals presiding over commitment hearings should be lawyers — preferably judges, but under some circumstances licensed attorneys appointed by the court. They should be thoroughly familiar with the state mental health laws and procedures, the constitutional principles applicable to commitment proceedings, and mental health and related social services available in the community. Their principal role should be that of an impartial fact finder.

Commentary

The National Task Force recognized variations throughout the country,[1] but nonetheless expressed a preference for judicial hearings before judges. Guideline F4 establishes such a general preference. Our legal system relies on judges to hear and to decide other types of proceedings in which liberty and the exercise of governmental authority over individuals are at issue. Commitment hearings deserve no less.

If limited judicial resources make it necessary to rely on nonjudicial decisionmakers, the guideline suggests that the presiding officer be an attorney licensed to practice law in the jurisdiction of the court, vested with the authority to issue the necessary orders, and able to decide impartially the matters-presented. Although psychological, medical, and social concerns are often the focus of a commitment hearing, the paramount issue is a legal one — the exercise of the government's police and welfare powers over an individual. The attorney acting as a hearing officer should be cloaked with the necessary authority and be free from obvious conflicts of interest, such as having any financial or personal interest in the matter or serving as counsel to a mental health department or facility. The guideline makes clear that before presiding over commitment proceedings, judges and attorneys must familiarize themselves with the issues, procedures, and options that they will face. In particular, they should have a working knowledge about the continuum of mental health treatment and care available to respondents in their jurisdiction (as may be described in the guide to mental health and social services prescribed in Guideline A2, "Continuum of Services: Directory").

Whether a judge or a nonjudicial officer presides over commitment hearings, provisions should be made to assure that the presiding officer understands the jurisdiction's mental health laws, is familiar with the technical terms and principles, knows the array of available local mental health treatment facilities, and is able to render fair and impartial decisions. Presiding officers should be assigned to hear commitment cases on more than an occasional basis. Infrequent duty may provide too little opportunity for knowledge and expertise to develop. However, to provide the requisite perspective and to avoid routinization, presiding over commitment hearings should not be an irreversible, long-term assignment. Members of the National Task Force agreed that the optimal assignment schedule should balance the need for hearing officers who are knowledgeable about the "law on the books" as well as the "law in practice" and the necessity to avoid "judicial burnout."[2]

Arguments about who is to preside over the commitment hearing focus on the status, prestige, and expertise of the hearing officer, as well as the use of judicial

resources. Some may argue commitment proceedings should be accorded the importance, visibility, and accountability that result from having a judge preside. However, it is suggested that because in most jurisdictions commitment hearings require only a small percentage of a judge's time and attention, most judges will not develop a detailed understanding of the legal and psychological principles involved in commitment hearings. A quasi-judicial officer whose primary judicial assignment is mental health proceedings would be more likely to become an expert and to give the proceeding the attention it deserves. Research and observations conducted by staff of the Involuntary Civil Commitment Project revealed no particular advantage to having hearings conducted by judges rather than by quasi-judicial officers. The differences in knowledge, attitude, and practice among those who preside over these hearings are apparently not correlated with status. Judges who are new and those who rotate in and out of the commitment case calendar, however, are usually less conversant with mental health law and procedure than those who hear such cases regularly and repeatedly.

Notes

1. Statutory authority to preside over commitment hearings is generally granted to a judge. In some states this authority is granted to judges of the court of general jurisdiction. E.g., Ariz. Rev. Stat. Ann. § 36-501.2. (Supp. 1985). In others, judges of courts of limited jurisdiction hear commitment cases. Some states permit quasi-judicial officers, such as referees, commissioners, and special justices, to preside over commitment hearings. *E.g*., Va. Code § 37.1-67.4 (1984). A few permit hearings to be held before an administrative panel. *See Doremus v. Farrell*, 407 F. Supp. 509 (1975) (addressing the issue of permissibility of hearing before an administrative panel).

2. One of the National Task Force members noted that in Chicago, judges in the County Division of the Circuit Court of Cook County are assigned to hear commitment cases for one week out of three.

F5. Duties of Respondents' Attorneys during Hearings

In the courtroom, an attorney should engage in all aspects of advocacy and vigorously argue to the best of his or her ability for the ends desired by the client.

An attorney's responsibilities during a commitment hearing include, but are not limited to, the following: raising procedural motions; making evidentiary objections; ensuring the respondent's presence at the hearing except in extraordinary circumstances; certifying the respondent's conversion to voluntary patient status, if that is the informed choice of the respondent; presenting and cross-examining lay and expert witnesses; presenting evidence of the respondent's unsuitability for commitment and offering alternatives to commitment; and presenting negotiated settlements to the court.

(a) A respondent who chooses to do so should attend the court hearing of the commitment case. If the respondent waives the right to be present at the hearing, the attorney should make a record of his or her advice to the respondent regarding the right to be present and the choice to waive that right.

If a respondent's attorney is authorized by law to waive the respondent's right to be present during civil commitment hearings without the consent or over the objection of the respondent, the attorney should avoid using this authority except in extraordinary circumstances, such as when the respondent unequivocally refuses to attend and cannot be encouraged to do so, when attending would jeopardize the respondent's mental or physical condition, or when the respondent's presence at the hearing would completely disrupt and prevent a meaningful proceeding. In such circumstances, the attorney should make a record of the facts relevant to a respondent's absence from the hearing.

(b) A respondent's attorney should offer evidence favorable to the respondent's case and present lay and expert witnesses, including an impartial, independent mental health expert who has examined the respondent. The attorney should also thoroughly examine and cross-examine adverse lay and expert witnesses, particularly regarding the factual bases of conclusory opinions about the respondent's suitability for commitment under the applicable legal standards.

(c) After discussions with the respondent and with his or her consent, the attorney should present evidence of appropriate alternatives to involuntary commitment, including, but not limited to, voluntary mental health treatment and commitment to community-based mental health treatment and care. Presentation of such evidence should focus not merely on the suitability of alternatives but also on the nature of actual alternatives available to the respondent in the community.

(d) When it will advance a client's interests, a respondent's attorney should cooperate with the state's attorney in presenting a negotiated settlement for adoption by court order.

Commentary

Guideline F5 requires respondents' attorneys to engage in all aspects of trial advocacy during commitment hearings. It highlights important duties of attorneys representing respondents at judicial hearings: assuring the presence of the respondent at the hearing, presenting and cross-examining witnesses, presenting evidence of appropriate alternatives to involuntary civil commitment, and presenting negotiated settlements. Many aspects of these duties are unique to involuntary civil commitment proceedings, and attorneys may not be as familiar with them as they are with other aspects of trial procedure.[1]

Generally speaking, attorneys should be encouraged to take an adversarial stance during judicial hearings. Such a stance is generally consistent with the canons of legal ethics.[2]

Counsel should clarify and fully explore all relevant issues, which may or may not have arisen during the discharge of his or her duties before the actual hearing (see Guideline E5, "Prehearing Duties of Respondents' Attorneys"), including (a) whether the case for commitment is based on dangerousness to self or to the person or property of others, (b) whether there is any real factual basis for determinations of dangerousness, (c) the probability of dangerous behavior in the future, (d) how well the respondent is currently functioning and whether any indications of poor functioning are due to the respondent's social situation or to mental disorder, (e) whether there is any useful purpose to hospitalization and whether possible alternatives exist or have been explored, (f) whether mental health examinations and screenings were thorough, (g) whether the respondent had recently been exhibiting abnormal or unusual behavior and whether the recommendations of the mental health professionals and other parties seeking to restrict the respondent's liberty are based on factual or conclusory data.[3]

Even though mental health professionals' opinions on the subject and inconvenience to hospital staff may militate against the presence of respondents at judicial hearings,[4] especially when hearings are conducted in a courtroom far removed from the mental health facility in which the respondent may have been detained,[5] paragraph (a) encourages the respondent's presence in the courtroom by requiring that the attorney waive the respondent's right to be present during commitment hearings only under extraordinary circumstances. Taking a strong position in favor of the respondent's presence at the hearing, this guideline also requires that counsel certify to the court that a respondent's waiver was made knowingly and voluntarily. This certification may relieve, but does not prevent, a court from inquiring into the reasonableness of the waiver.

Although respondents infrequently refuse to attend commitment hearings, if a respondent does refuse, the attorney should carefully inquire into his or her motivation. It may be that the respondent's ignorance of the proceeding's nature has produced unreasonable fear that counsel can allay through sensitive discussion and explanation.

In addition to urging the presentation of evidence favorable to the defense, paragraph (b) of Guideline F5 encourages appropriate cross-examination of mental health expert and lay witnesses. Conclusory or baseless opinions should not go unchallenged. In a technical sense, respondents should be afforded every legal protection that has been provided for them. Relevancy and hearsay rules, for example, are intended to ensure that the state presents reliable evidence in its case for commitment. The rules are effective, however, only if a respondent's counsel vigorously objects to noncomplying evidence. Counsel's failure to challenge conclusory assertions (e.g., rephrasing of statutory language or unexplained diagnosis, such as "schizophrenia-chronic undifferentiated") is damaging not only to the respondent's case against commitment but also to the court's ability to reach a well-informed and proper decision. It is incumbent upon a respondent's counsel to present the facts in a form that will assist the judge in reaching a just result. If counsel fails to fully meet this responsibility, the court should exercise its authority and pursue an explanation of the facts. This may be accomplished either by encouraging counsel to question a mental health expert witness further or by the court itself questioning the witness. Because it is the court's duty to ensure a full and fair presentation of the evidence, the court can and should exercise its discretion in these matters.

Although most state laws explicitly permit the court to consider alternatives to the commitment of a respondent to a public mental health hospital,[6] it is unclear who should bear the burden of producing evidence regarding appropriate alternatives. Paragraph (c) encourages the respondent's counsel to present such evidence. Technically, the state bears not only the burden of proving "committability" but also the burden of proving that the treatment and care recommended (usually hospitalization) is the least restrictive alternative appropriate, given the respondent's condition.[7] As a practical matter, the responsibility for investigating and offering less restrictive alternatives to hospitalization often falls on the respondent's counsel.

Once the state has presented its evidence supporting the treatment and care it advocates, the burden shifts to the respondent's counsel to rebut that evidence and to present alternatives to the court. The attorney representing the state has neither the responsibility nor the incentive to present the court with less restrictive alternatives.[8] The respondent's counsel has the incentive to explore and to present evidence of less restrictive alternatives, stemming from his or her obligation to protect the client's liberty interests. Once the respondent's counsel presents such evidence, the court must determine whether the state's contrary evidence regarding dispositional options clearly and convincingly outweighs the respondent's evidence.

Conferences and negotiations regarding the settlement of a case prior to a commitment hearing are not included as a formal part of the hearing unless one of the parties presents the settlement proposal to the court. Paragraph (d) of Guideline F5 provides that the respondent's attorney should cooperate with the state's attorney in presenting a settlement proposal to the court. Although serious questioning and rejection of stipulated agreements by the court may be infrequent, the presentation of a

negotiated settlement as part of a formal hearing has the advantage of giving an opportunity to question aspects of the settlement and to disclose conditions of the settlement agreement to all parties.[9]

Notes

1. Guideline F5 complements the guidelines in Part E, "Legal Representation," which focus on the prehearing phase of commitment proceedings, and Guideline H1, "Posthearing Duties of Respondents' Counsel."

2. [A]lthough [the attorney] should be a counsellor and negotiator in the prehearing stages, he must be an adversary in the courtroom, for no other role there seems possible. Naturally, different tactics and emphasis will suggest themselves in accordance with counsel's estimates of the truthfulness of witnesses, the validity of diagnostic and prognostic data, and the likelihood and feasibility of various dispositional alternatives. But such variables occur in all litigation, and do not vitiate the lawyer's basic role as a partisan combatant. It is not his responsibility to decide the "best interests" of the community, or whether the client is dangerous to himself or others, but rather to present effectively the client's side of the case, so that the court may make an informed judgment on these issues.

Blinick, *Mental Disability, Legal Ethics, and Professional Responsibility*, 33 Albany L. Rev. 92, 115 (1968) (emphasis in original). *See also Anders v. California*, 386 U.S. 738, 744 (1967) (recognizing that the constitutional requirement of "substantial equality and fair process" is obtained only when counsel acts in the role of an active advocate on behalf of the client).

3. *See* Litwack, *The Role of Counsel in Civil Commitment Proceedings: Emerging Problems*, 62 Calif. L. Rev. 816, 827-31 (1974); D. Wexler, *Mental Health Law: Major Issues* 98 (1981). For a discussion of certain technical problems involved in representing individuals at civil commitment hearings, such as challenging hearsay and opinion evidence and deciding whether the client should testify, *see* Golten, *Role of Defense Counsel in the Criminal Commitment Process*, 10 Am. Crim. L. Rev. 385 (1972); J. Ziskin, *Coping with Psychiatric and Psychological Testimony* 205-79 (1970); *How to Represent Clients at Mental Commitment Hearings*, 23 Legal Aid Brief Case 19, 20 (1964). A difficult question is whether an allegedly mentally ill person has a right to waive the right to counsel; see Note, *The Right to Counsel at Civil Competency Proceedings*, 40 Temp. L.Q. 381, 390-92 (1967).

4. *See* D. Wexler, *supra* note 3, at 97.

5. *See* Commentary, Guideline F3, "Location of Hearings."

6. *See, e.g.*, Me. Rev. Stat. Ann. tit. 34-B, § 3864.6.A(2) (Supp. 1985); Va. Code § 37.1-67.3 (1984); Ill. Ann. Stat. ch. 91 1/2, § 3-811 (Smith-Hurd Supp. 1985); Mich. Comp. Laws Ann. § 330.1469 (West Supp. 1985). *See generally* Keilitz & Hall, *State Statutes Governing Involuntary Outpatient Civil Commitment*, 9 Mental & Physical Disability L. Rep. 378 (1985).

7. *See, e.g.*, Wis. Stat. Ann. § 51.20(13)(e) (West Supp. 1985) (placing the burden of proving that the recommended treatment is the least restrictive alternative on the attorney for the state).

8 *See* I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 96-97 (1983). In some cases observed in Milwaukee County, the evidence presented by the state regarding the availability of less restrictive alternatives to hospitalization consisted of the attorney asking the mental health expert witness, "Would you recommend this facility for treatment?" and the examiner responding affirmatively without explanation. Generally speaking, such leading questions and conclusory responses by a mental health expert witness should be insufficient to carry the state's burden of proof if a respondent's attorney challenges the adequacy of that evidence and presents less restrictive alternatives to the court. *Id*.

9. *See* Guideline D7, "Negotiated Settlement of Cases."

F6. Hearing before a Jury

If a jurisdiction permits jury trials in commitment cases, a jury trial should not be waived unless counsel for the respondent has discussed the availability of a jury trial with the respondent and counsel reasonably believes that the waiver was made knowingly.

Commentary

Although the Constitution has not been construed to guarantee a right to a hearing before a jury,[1] some state laws entitle respondents in involuntary commitment proceedings to request a jury trial. In most of these states, this right applies to the commitment hearing;[2] in others, the right to a jury trial applies only if a trial *de novo* has been requested.[3] In those jurisdictions that permit jury trials, this right is infrequently exercised. It is unclear whether respondents fail to request a jury because of inconvenience considerations (jury trials generally are held in the courthouse rather than the hospital), privacy considerations, or lack of notice of this right. It is also unclear whether a jury or a judge is more likely to commit the respondent. In these jurisdictions, a court should ensure that a respondent has been advised of the right to a jury. Also, the court should make sure that a purported waiver is made knowingly and voluntarily.

Guideline F6 applies only to jurisdictions that recognize affirmative waiver of a jury trial by the respondent. As do other waiver provisions in these guidelines, it directs the attorney for the respondent to explain to the respondent the benefits and detriments of a jury trial and, if the respondent chooses not to have a jury, to certify that this decision was made knowingly and voluntarily. Counsel should notify the court of the respondent's decision sufficiently before the hearing to permit the necessary scheduling and arrangements.

Notes

1. *See Lynch v. Baxley*, 386 F. Supp. 378, 394 (M.D. Ala. 1974); *cf. Markey v. Watchtel*, 264 S.E.2d 437 (1979).

2. *E.g.*, Cal. Welf. & Inst. Code § 5302 (West 1984); Ill. Ann. Stat. ch. 91 1/2, § 3-802 (Smith-Hurd Supp. 1985); N.M. Stat. Ann. § 43-1-12.B (1984) (for extended commitments only).

3. *See, e.g.*, Va. Code § 37.1-67.6 (1984); N.Y Mental Hyg. Law § 9.35 (McKinney 1986).

F7. Respondents' Rights at Hearings

A respondent should be afforded legal representation at a commitment hearing. He or she should have the right to present favorable witnesses, to confront and cross-examine adverse witnesses, and to participate fully in all aspects of the hearing. The

respondent's rights, including those relating to privileges and benefits under law, should not be abridged or qualified solely because he or she is proposed for civil commitment or has been involuntarily evaluated or confined for treatment purposes.

(a) A respondent should be encouraged to exercise his or her right to be present at hearings. If a respondent wishes to waive that right, such a waiver should be accepted only if the court determines that the waiver was made knowingly and voluntarily. In jurisdictions permitting counsel to waive the respondent's right to be present over his or her objection, a court should accept the waiver only if it is satisfied, by a clear showing on the record, that the respondent's attendance at the hearing would subject him or her to risk of emotional or physical injury.

(b) The court may remove a respondent from a hearing because of disruptive behavior. However, it should do so only if, after the court's warning, the disruptive behavior continues and substantially impedes the conduct of the hearing. Once removed, the respondent should be permitted to return to the hearing if the disruptive behavior subsides.

(c) At the time of the hearing, a respondent may be under the influence of psychotropic or other prescribed medications. In such case, counsel for either party should be permitted to introduce evidence regarding the nature of the medication and its likely effect on the respondent's demeanor.

Commentary

Guideline F7 reflects the National Task Force's strong preference for the respondent's presence at civil commitment hearings.[1] As with any judicial or administrative proceeding, communication between the respondent and his or her attorney during the hearing is often critical. Because of physical disability or severe mental illness, some respondents may prefer not to attend or may not be able to attend. Hence, a waiver procedure is provided. The guideline places responsibility on counsel for ensuring that the respondent is apprised of his or her right to attend and that a waiver of that right is not the result of duress or coercion.

Medication that affects appearance, movement, or speech is frequently administered to respondents following an emergency commitment or at other times before the civil commitment hearing. The side effects of such medication can affect the outcome of the proceeding. It may make the respondent appear to be more disoriented than he or she actually is. It may prevent or impede the respondent from assisting counsel during the hearing. It may improve the respondent's demeanor and appearance. In any case, to alleviate the prejudicial effect of such medication, paragraph (c) urges that the trier of fact be informed that the respondent is under the influence of such medication and be apprised of its likely effects.[2]

At least three general questions should be considered regarding a respondent's attendance at a hearing: Should it be encouraged? Under what circumstances should a waiver be accepted? What additional protection, if any, should be in place if the respondent is under the influence of psychotropic medication? Members of the National Task Force believe that the respondent's presence is important so that he or she may assist counsel in defending against the commitment. Such assistance may be particularly helpful in commitment proceedings, where the opportunity for prehearing discovery is typically quite limited. In addition, some observers maintain that exposing the respondent to the hearing process may enhance his or her amenability to further treatment. From the perspective of the court, personal observation of the respondent may be an invaluable tool in decisionmaking. At a minimum, it should reduce reliance on third-party observations, written records, and hearsay evidence.

Several arguments have been advanced to justify exclusion of the respondent from the hearing: family members or close friends may be reluctant to testify, adverse testimony may be emotionally harmful to the respondent, and the respondent's illness may manifest itself in disruptive outbursts. Although these concerns are important, most can be addressed through prehearing counseling, use of appropriate hearing rooms, and adequate procedures for removal of disruptive respondents.[3]

Some National Task Force members expressed concern that a waiver of the respondent's right to attend the hearing may be the result of pressure exerted by counsel for tactical reasons. Obviously, the presence of a severely disturbed or disoriented respondent may influence the outcome of the proceeding. Therefore, counsel may seek to shield the respondent from the eyes and ears of the court. Given the importance of the respondent's presence, however, the court should demand assurances that the respondent's waiver was made knowingly and voluntarily. Accordingly, the court should not accept a waiver unless counsel states on the record that the respondent is aware of the right to be present, that the implications of not attending the hearing have been explained and discussed with the respondent, and that the waiver is not the result of duress or coercion.

In jurisdictions where the presence of the respondent is a requirement rather than a right and in jurisdictions where the respondent's attorney is permitted to waive the respondent's presence at the hearing, the court should excuse the respondent only if his or her presence at the hearing would be harmful to the respondent or if the respondent would be disruptive to the proceedings.[4] Because, as discussed above, these potential adverse consequences can often be greatly reduced or eliminated, the court should encourage the respondent's presence.

Notes

1. Most state codes provide a respondent a right to be present at the involuntary commitment hearing. *E.g.*, Ariz. Rev. Stat. Ann. § 36-539.B (Supp. 1985); Ind. Code Ann. §§ 16-14-9.1-9(e)(3), 16-14-9.1-10(c) (Burns Supp. 1985); Okla. Stat. Ann. tit. 43A, § 54.4.H (West Supp. 1985); Mich Comp. Laws Ann § 330.1455 (West Supp. 1985). Others treat the respondent's presence as a procedural requirement. E.g., Ill. Ann. Stat. ch. 91 1/2, § 3-806 (Smith-Hurd Supp. 1985); W. Va. Code § 27-5-4(g)(1) (Supp. 1985); N.C. Gen. Stat. § 122C-267(b) (1985); Cal. Welf. & Inst. Code § 5256.3 (West 1984). Many either permit a waiver of the right or provide an exception to the requirement. The grounds for a waiver or an exception are either that the respondent's presence at the hearing would be detrimental to his or her health (*e.g.*, Ariz. Rev. Stat. Ann. § 36-539.C (Supp. 1985); Ill. Ann. Stat. ch. 91 1/2, §3-806 (Smith-Hurd Supp. 1985); Okla. Stat. Ann. tit. 43A, §54.4.H (West Supp. 1985); Idaho Code §66-329(j) (Supp. 1985)) or that the respondent would disrupt the proceeding, (e.g., Ind. Code Ann. § 16-14-9.1-9(e)(3), 16-14-9.1-10(c) (Burns Supp. 1985); Okla. Stat. Ann. tit. 43A, § 54.4.H (West Supp. 1985); Idaho Code § 66-329(j) (Supp. 1985)). Utah allows waiver of the respondent's presence at the hearing only for "good cause" shown with reasons to be stated on the record. Utah Code Ann. § 647-36(g) (Supp. 1983).

2. Medication may be either helpful or damaging to the respondent's case, depending upon the respondent's reaction to the medication at the time of the hearing, the counsel's characterization of that reaction, and the court's response to the counsel's representation. Medication is often used to calm a respondent, or it may have the secondary effect of calming the respondent. On the one hand, a respondent may appear dazed or may exhibit other behavior due to the medication rather than to an actual mental or physical condition. Not only may medication severely impair a respondent's ability to assist counsel, but also drug-related inappropriate appearance or behavior may substantially contribute to a court's decision that the respondent meets the commitment criteria. On the other hand, administration of psychotropic medication may stabilize a respondent's condition so that his or her functioning is so dramatically improved that the case for commitment is impossible to prove. In any event, the trier of fact should inquire concerning the effects of the drug so that the alteration of the respondent's appearance, demeanor, or actions does not improperly influence the decisionmaking process.

3. Barring a potentially disruptive respondent from a commitment hearing is no more necessary than barring a potentially disruptive defendant from a criminal proceeding. For instances in which a respondent continually disrupts the hearing, the guideline adopts the procedures applicable to criminal defendants. Thus, a respondent may lose the right to be present only if he or she persists in disrupting the proceedings after the judge has warned him or her of the consequences. Once removed, a respondent should be permitted to return as soon as he or she is willing and able to conduct himself or herself "consistently with the decorum and respect inherent in the concept of . . . judicial proceedings."

> Public confidence in the trial process requires that removal . . . be limited to cases urgently demanding that action be taken, that it be done only after explicit warning, that there be a standing opportunity . . . to return to the courtroom, and that the burden that absence creates . . . be kept to the unavoidable minimum.

Illinois v. Allen, 397 U.S. 337, 343 (1970). *American Bar Association Standards for the Administration of Criminal Justice: Special Functions of the Trial Judge* 18 (2d ed. Approved Draft 1978). The *Illinois v. Allen* standards for removing a disruptive criminal defendant could be effectively used in commitment proceedings.

4. *See* Ill. Ann. Stat. ch. 91 1/2, § 3-806 (Smith-Hurd Supp. 1985); Ind. Code Ann. § 16-14-9.1-9(e)(3) (Burns Supp. 1985).

F8. Rules of Evidence and Procedure

To facilitate efficient presentation of all relevant evidence, with proper regard for the important interests at stake, the rules generally applicable to civil proceedings should govern civil commitment hearings.

Commentary

Although civil commitment may result in a deprivation of the respondent's liberty, civil commitment is a civil proceeding. Thus, the guideline provides that the evidentiary and procedural rules applicable in other civil trials should govern civil commitment hearings.[1]

Although in most states the rules of civil procedure apply to the commitment process,[2] there is considerable variation regarding the extent to which hearsay evidence is admissible at such hearings. Hospital records are generally admitted under an exception to the hearsay rule that permits introduction of "official records kept in the normal course of business,"[3] but difficult questions arise with respect to the admissibility of observations of examining psychiatrists and other facility staff that are not made part of the hospital record. Similarly, there is no uniform practice regarding the admissibility of *past* medical records and impressionistic reports written by public or private psychiatrists working in community-based settings. In most jurisdictions, these reports are generally admitted, but they should not be viewed as a substitute for testimony which proves or disproves the allegations contained in the commitment petition.

States that follow the Federal Rules of Evidence regarding the scope and admissibility of expert testimony permit an expert to testify on the basis of facts or dates "made known to [the expert] at or before the hearing" so long as the information received prior to the hearing is "of a type reasonably relied upon by experts in the particular field in forming opinions or inferences upon the subject."[4] Some jurisdictions have more restrictive rules,[5] but in the final analysis most expert testimony will be admitted if it is relevant to the respondent's diagnosis and prognosis. To ensure that liberal admission of expert testimony is not abused, however, the respondent should be permitted to subpoena members of the treatment staff with whom the testifying examiner consulted.

Another difficult issue is the admissibility of evidence of previous commitment and evidence of pending criminal charges. National Task Force members take the position that evidence of prior commitments should be admissible for purposes of determining a respondent's diagnosis and for treatment planning, but under no circumstance is such evidence sufficient to prove that the respondent meets the criteria for commitment.

The existence of pending criminal charges should not be admissible in civil commitment proceedings. Such allegations have not been proven and, therefore, should not be relied upon to support the allegation that the respondent meets the criteria for civil commitment. However, evidence of the conduct underlying the criminal

charge should be admissible. Adoption of the evidentiary format proposed in Guideline G1 — bifurcating the adjudicative and dispositional issues — should limit the prejudical effect of the admission of such evidence.[6]

Notes

1. *See Lessard v. Schmidt*, 413 F. Supp. 1318 (E.D. Wis. 1976); *Lynch v. Baxley*, 651 F.2d 387 (5th Cir. 1981); *Doremus v. Farrell*, 407 F. Supp. 509 (D. Neb. 1975); *Suzuki v. Quisenberry*, 411 F. Supp. 1113 (D. Hawaii 1976); *Commonwealth ex rel. Finken v. Roop*, 339 A.2d 764 (Pa. Super. Ct. 1975), *cert. denied*, 424 U.S. 960 (1976); *State ex rel. Hawks v. Lazaro*, 202 S.E.2d 109 (W. Va. 1974). *Cf.* American Psychiatric Association, *Guidelines on Psychiatric Hospitalization of Adults*, in American Psychiatric Association, *Issues in Forensic Psychiatry*, Guideline 6.D.5 (1984).

> The rules governing evidentiary and procedural matters at hearings under this Act shall be applied so as to facilitate informal, efficient presentation of all relevant, probative evidence and resolution of issues with due regard to the interests of all parties. Hearsay evidence may be received, and experts and other witnesses may, consistent with law, testify to any relevant and probative facts at the discretion of the court.

Id. at 41.

2. *See, e.g.*, Colo. Rev. Stat. § 27-10-11(1) (1982); Idaho Code § 66-329(j) (Supp. 1985); Me. Rev. Stat. Ann. tit. 34-B, § 3864.5.C (1985); Mich. Comp. Laws Ann. § 330.1459(2) (West 1980); Ohio Rev. Code Ann. § 5122.15(A)(15) (Page Supp. 1984). *But see* Cal. Welf. & Inst. Code § 5256.4(b) (West 1984) (the person conducting the hearing shall not be bound by rules of procedure or evidence applicable in judicial proceedings).

3. Fed. R. Evid. 803(6). *See People v. Germich*, 431 N.E.2d 1029 (Ill. App. Ct. 1981).

4. *See, e.g.*, Ariz. R. Evid 703; N.J.R. Evid. 56(2); *see also* Fed. R. Evid. 703.

5. *See, e.g.*, Mich. R. Evid. 703; Ohio R. Evid. 703.

6. For a discussion of the rules of evidence governing commitments, see A. D. Brooks, *Law, Psychiatry, and the Mental Health System* 806-08 (1974); S.J. Brakel, J. Parry, & B. A. Weiner, *The Mentally Disabled and the Law* 66-7 (3rd. ed 1985).

F9. Witnesses

The presentation of witnesses is an integral part of the adversary process. Therefore, each party should be given broad authority to subpoena witnesses and to conduct thorough examinations and cross-examinations of all witnesses during a commitment hearing. Except in extraordinary circumstances, the court should hear the testimony of at least one person who observed the conduct that led to the filing of the commitment petition, and from at least one psychiatrist or clinical psychologist who personally examined the respondent after the filing of the petition or after the respondent was taken into custody.

Commentary

Guideline F9 contains both a general entitlement provision and specific recommendations regarding witness testimony required to support the allegations in the petition. First, it recommends that all parties to a commitment proceeding (the petitioner, the state, and the respondent) have the right to subpoena witnesses and evidence and to cross-examine witnesses called to testify.[1]

Second, Guideline F9 recommends that the court hear testimony from at least one lay or expert witness who has observed the respondent's behavior — preferably close to the time the respondent was taken into custody or a petition was filed — and at least one expert witness who has examined the respondent close to the time of the commitment hearing. To substantiate the allegations in the commitment petition, the guideline indicates a preference — but not a requirement — for the testimony of witnesses who observed the respondent before he or she was taken into custody or a petition was filed. Although such testimony is very important, National Task Force members recognize that it may not always be possible to secure it; e.g., family members may be reluctant to testify against their relatives.

Although law requires a full evidentiary hearing and direct evidence, few statutes specify that a psychiatrist or clinical psychologist who has examined the respondent must actually testify at the commitment hearing. Of those that do, some require the testimony of two physicians who have personally examined the respondent,[2] and others require the testimony of only one mental health expert.[3] If testimony of one or more examiners is required, statutes often allow a waiver by respondent's counsel[4] or by the court.[5]

The expert witness should be a psychiatrist or clinical psychologist who has personally examined the respondent and is prepared to offer opinions regarding the presence of mental illness, the respondent's current condition, and what, if any, types of treatment should be provided. By implication, the guideline discourages the practice which exists in some jurisdictions of having one mental health professional testifying at all the hearings held on a particular day, unless that professional has conducted the required examination of each respondent. From the standpoint of convenience, the hospital may well prefer to have one expert present in court testifying from the notes of the experts who actually examined the respondent; this interest is overridden, however, by the respondent's interests in questioning the examiners personally about their observations and conclusions. By establishing adequate notice and scheduling procedures and by holding hearings at the treatment facility (see Guideline F3, "Location of Hearings"), the time required of and inconvenience to the examiners can be substantially reduced. In jurisdictions requiring that a respondent be examined by two examiners (excluding an independent examiner requested by the respondent), the second examiner should not be required to testify if the examination reports are in substantial agreement and the respondent's counsel consents.

Having an examiner present gives the parties and the court an opportunity to probe the statements and con-

clusions contained in written reports by the examiner. This may be critically important when a respondent's liberty depends on definitions, diagnosis, predictions, and prescriptions which may be subject to intense disagreement. For several reasons, psychiatrists and clinical psychologists may be reluctant to testify. It is inconvenient, particularly when hearings are not held in the treatment facility. The time spent traveling to the courthouse and waiting to testify is time away from seeing patients and performing other duties. It is unpleasant to have one's professional opinions questioned by laypeople. Mental health professionals often are confused about their role in the commitment process. Are they neutral purveyors of facts about the respondent? Are they advocates for the party who called them to testify? Are they agents of the court or the hospital? These are difficult issues which have created serious tension between mental health professionals and the legal system. But these professionals must understand that, for better or worse, they play an exceedingly important role in the process. Their observations, diagnoses, and opinions may mean the difference between a person's release and his or her confinement. To help familiarize mental health professionals with the legal process and their role in it, orientation materials should be made available.

In the interest of encouraging the testimony of the examining physician as well as to reduce strain on the respondent, hearings may be held in an appropriate room in a treatment facility (see Guideline F3). Some jurisdictions may wish to experiment with testimony via closed-circuit television. Although this may be costly, it would allow hearings to take place virtually anywhere, court or hospital. Doctors could be called to "take the stand" electronically, on a television hookup, only when their testimony is needed.

Although many current statutes permit testimony of lay witnesses, only a few require testimony from individuals who are acquainted with the respondent[6] or who have observed his or her behavior.[7] Lay testimony may be a key in determining whether the respondent can remain in a family or community setting while receiving treatment. Hence, a court should encourage the petitioner and other individuals who have observed the respondent's actions to share that information at the hearing. If the petitioner is seeking to prove dangerousness, testimony from individuals who have observed the respondent's actions is particularly useful. If, however, the matter to be proved is the underlying mental illness, lay testimony may be less important.

Notes

1. The rights to present and cross-examine witnesses are at the core of the American judicial process. Because decisions affecting a respondent's liberty may often hinge on subjective interpretations of ambiguous behavior and responses, these rights are particularly important in commitment proceedings. Many current statutes, however, make only vague reference to these rights. Hence, courts should clarify these rights through daily practice and rulemaking.

2. *See, e.g.*, Ariz. Rev. Stat. Ann. § 36-539.B (Supp. 1985).

3. *See, e.g.*, Ill. Ann. Stat. ch. 91 1/2, § 3-807 (Smith-Hurd Supp. 1985); Mich. Comp. Laws Ann. § 330.1461 (West Supp. 1985); Va. Code § 37.1-67.3 (Supp. 1985).

4. *See, e.g.*, Va. Code § 37.1-67.3 (Supp. 1985); *see also* Cal. Welf. & Inst. Code § 5276.1 (West 1984) (at a judicial review hearing, the respondent, upon counsel's advice, may waive the expert's presence at the hearing).

5. *See, e.g.*, Ill. Ann. Stat. ch. 91 1/2, § 3-807 (Smith-Hurd Supp. 1985) (the respondent may waive such testimony upon court approval).

6. *See, e.g.*, Ariz. Rev. Stat. Ann. § 36-539.B (Supp. 1985).

7. *See, e.g.*, Ind. Code Ann. § 16-14-9.1-7(e) (Burns Supp. 1985) (at preliminary, probable cause hearings only).

F10. Public Access to Hearings

Judicial proceedings that are kept from public view may contribute to misunderstanding, distrust, and a lack of public confidence in the judicial system. In the context of civil commitment, such proceedings may also reinforce the public's misconceptions about mental illness. Nevertheless, the overriding interest in protecting the privacy of persons proposed for commitment has led many states to enact laws placing control on public access to court hearings in the hands of the respondent.

In order to enhance accountability and public confidence, courts should encourage public access to court hearings. Even in cases in which courts restrict public access, researchers, trainees preparing for court service, and others with a legitimate professional interest in commitment proceedings should only be barred from hearings if the respondent or counsel so requests.

Commentary

Guideline F10 encourages public access to commitment hearings. Such access improves accountability and enhances confidence in the judicial system. It also serves legitimate research and pedagogic purposes, which may improve the quality and understanding of the civil commitment process.

> Secrecy of judicial action can only breed ignorance and distrust of courts and suspicion concerning the competence and impartiality of judges; free and robust reporting, criticism, and debate can contribute to public understanding of the rule of law and to comprehension of the functioning of the entire . . . justice system, as well as improve the quality of that system by subjecting it to the cleansing effects of exposure and accountability.[1]

The issue of public access to commitment hearings provokes strong feelings on both sides. Most statutes fail to address whether the public may have access to involuntary commitment hearings.[2] Those that do establish an access rule generally entitle the respondent to waive the rule. For example, some states provide for a closed

hearing unless the respondent requests[3] or permits[4] an open hearing. In other states, the hearing is open unless the respondent shows good cause to close it[5] or unless the respondent specifically requests that the hearing be closed.[6]

The guideline would permit a respondent to request a closed hearing to protect his or her privacy. Such requests should be granted, unless the respondent has made his or her mental health an issue in a related public proceeding (e.g., if the commitment proceeding is the result of the respondent having been found not guilty by reason of insanity in a related criminal proceeding). The public's strong interest in the proceeding in such situations may outweigh the respondent's privacy interest.

A respondent's attorney should explain to his or her client the available options for open or closed hearings. If the court approves a respondent's request for a closed hearing, all persons except the parties, their witnesses, and others specifically approved by the court should be directed to leave the courtroom. Those persons permitted to remain should be instructed not to discuss the proceedings with the public or the press.

State law notwithstanding, in practice, in the overwhelming majority of commitment cases, hearings are attended only by family members, witnesses, mental health professionals, and attorneys. Only in cases of great notoriety do members of the public and the press seek the opportunity to attend. Of course, it is in these cases where a conflict between the interests of the respondent and those of members of the public is likely to arise. In jurisdictions in which involuntary commitment hearings are open, an important role of a community coordinating council (see Guideline A1) may be to discuss with the local news media the development of voluntary standards for the proper subject matter for news reporting.[7]

Notes

1. *Nebraska Press Association v. Stuart*, 427 U.S. 539, 587 (1976) (Brennan, J., concurring). The American Psychiatric Association takes a different position in its guideline 6.D.7:

> The hearing shall be closed to the public, unless the respondent requests that it be open or the court determines for other good cause that the hearing should be open.

Guidelines for Legislation on the Psychiatric Hospitalization of Adults, in American Psychiatric Association, Issues in Forensic Psychiatry 41 (1984).

2. State laws may be divided into two major categories. The first category includes those statutes that make specific reference to public access and *criminal* commitment. The second category encompasses those statutes that mention public access to hearings only in terms of involuntary *civil* commitment whereby the trial court "loses" jurisdiction and a civil court (usually a probate court) gains jurisdiction over criminal defendants who are determined to be either permanently incompetent to stand trial or, once tried, not guilty by reason of insanity. These two categories represent the two major schemes used by states for detaining mentally disordered criminal defendants.

The first statutory category is numerically small, for only four states, including Pennsylvania under a proposed statute, specifically mention public access to criminal commitment proceedings. Ohio law declares that commitment hearings on persons found not guilty by reason of insanity should be open to the public. Ohio Rev. Code Ann. 5122.15(A)(5) (Page Supp. 1984). In Massachusetts, all reports of examinations, petitions in commitment, notices, orders, and other commitment papers used in criminal commitment hearings are private, except at the discretion of the court. Mass. Gen. Laws Ann. ch. 123, § 36A (West Supp. 1985). However, public inspection of any complaints or indictments and notation in the ordinary docket are allowed in criminal cases. *Id*. The original commitment hearing of insanity acquittees and persons incompetent to stand trial is in open court in Nevada. Nev. Rev. Stat. § 178.415(2) (1981).

Most state statutes fall within the second major category. Here, public access is mentioned only in the procedures for involuntarily civilly committing a criminal defendant. This category may be divided into two subcategories. The first subcategory contains statutes that prescribe either closure or openness (hereinafter, "nondiscretionary"), whereas the second allows discretion in providing public access to hearings.

Statutes in the nondiscretionary subcategory allow no choice in deciding whether the commitment proceedings are open or closed. Only three states are this absolute in their statutory language. West Virginia law states that evidence from interested parties *shall* be heard in chamber. W. Va. Code § 27-5-4(i)(1) (Supp. 1985). In contrast, Illinois law holds that evidence of mental illness *shall* be presented in open court. Ill. Ann. Stat. ch. 38, § 1005-2-4(g) (Smith-Hurd Supp. 1985). However, most states are more discretionary in their statutes. Arkansas, while holding that a ninety-day commitment hearing *must* be conducted in public and open to the news media, allows closure in extended stay hearings upon a patient's written request. Ark. Stat. Ann. §§ 59-1409,-1410 (Supp. 1985).

Discretionary statutes form the second subcategory under the involuntary civil commitment heading. These statutes usually permit either the defendant or the court to decide whether the hearing will be open or closed to the public. Within this subcategory there are three types of public access statutes. The first type of discretionary statute has a presumption in favor of public access, whereas the second type favors closure. The last type of statute allows the court to exclude all persons not necessary in the conduct of the proceedings.

The first type of discretionary statute, found in six states, has a presumption in favor of public access unless certain events develop. Those events include a request for closure by the defendant. *E.g.*, Ala. Code § 22-52-9(4) (1984); Ga. Code Ann. § 37-3-1(8) (1982); Wis. Stat. Ann. §§51.20(12) (West Supp. 1985). In addition to making a request, a defendant in Texas must show good cause for such a closure. Tex. Stat. Ann. art. 5547- 48(c) (Vernon Supp. 1985). Common law in Florida has a three-part test closely related to the "good cause shown" standard. *Miami Herald Publishing Co. v. Chappell*, 403 So. 2d 1342 (Fla. Dist. Ct. App. 1981). Similarly, Tennessee requires three conditions for closure: (1) the defendant must make the request, and the closure must serve both (2) the public's and (3) the defendant's interests. Tenn. Code Ann. § 33-3-610 (Supp. 1985).

The second major type of discretionary statute is the opposite of the first in that it has a presumption in favor of closure unless certain events occur. The most common form of this type of statute, found in four states, requires closure unless the defendant asks for an open hearing. Hawaii Rev. Stat. § 334-126 (Supp. 1984) (involuntary outpatient treatment hearings); Me. Rev. Stat. Ann. tit. 34-B, § 3864(H) (Supp. 1985); Neb. Rev. Stat. § 83-1055 (1981); N.C. Gen. Stat. §122-58.7(g) (1981). With one minor variation, the state of Washington falls within this type. In addition to an open hearing upon the defendant's request, the court may allow a limited number of health care personnel to attend for training purposes. Wash. Ment. P.R. 1.3. In California, any party to the proceeding may demand that the hearing be made public. Cal. Welf. & Inst. Code § 5118 (West 1984). Ohio's statute for commitment of persons incompetent to stand trial is similar, allowing the defendant to request an open hearing. Ohio Rev. Code Ann. § 5122.15(A)(5), (A)(6) (Page Supp. 1984). However, Ohio also permits the court to admit, without a request by the defendant, persons with a legitimate interest in the proceedings upon a showing of good cause. *Id*. New Jersey's hearings are *in camera* and may be opened to the public only upon a showing of good cause. N.J. C.P.R. 4:74-7(e).

The last and most common type of discretionary statute concerning closure of commitment proceedings allows the exclusion of all persons not necessary for the conduct of the proceedings. Six states have this type of statute, with no variation in language. Kan. Stat. Ann. § 59-2917 (1983); Ky. Rev. Stat. § 202A.076(1) (1983) (preliminary hearings); S.C. Code Ann. § 44-17-570 (Law. Co-op. 1985); Utah Code Ann. § 64-7-36(9) (Supp. 1983), Vt. Stat. Ann. tit. 18, § 7615(e) (Supp. 1985); Wyo. Stat. § 25-10-110(h) (1982). Variations on this type of discretionary statute occur in North Dakota and in Iowa incompetent-to-stand-trial hearings, where, at the court's discretion, persons not necessary for the conduct of the proceedings but with legitimate interests in them are allowed to attend. Iowa Code Ann. § 229.12(2) (West 1985); N.D. Cent. Code § 25-03.1-19 (Supp. 1985). Minnesota law has another variation on this type of statute; it allows the defendant to request attendance of nonnecessary people at the hearing. Minn. Stat. Ann. § 253B.08(3) (West 1982). New York also excludes all nonnecessary people except for a limited number of health and legal trainees, the news media under certain restrictions, and any other persons approved by the court. N.Y.R. CT. § 694.7(c) (McKinney 1984).

A few states do not fall easily into any of the three major types of discretionary statutes. Hearings in Alaska and Missouri are open or closed as the defendant elects. Alaska Stat. §47.30.735(b)(3) (1984); Mo. Ann. Stat. § 632.335.2(6) (Vernon Supp. 1985). New Hampshire permits either the respondent or the superintendent of the mental institution to request an open or closed hearing. N.H. Rev. Stat. Ann. § 135:30-a(V.) (1977). Montana allows closure for the protection of the defendant. Mont. Code Ann. § 53-21-126(3) (1984). Kentucky holds that final hearings may be held in chambers, whereas Indiana grants the defendant, the petitioner, and all other interested parties an opportunity to appear and testify at the hearing. Ky. Rev. Stat. § 202A.076(2) (1982); Ind. Code Ann. § 16-14-9.1-9(d) (Burns Supp. 1985).

3. N.C. Gen. Stat. § 122C-268(h) (1985).

4. Ohio Rev. Code Ann. § 5122.15(A)(5), (A)(6) (Page Supp. 1984).

5. N.J. C.P.R. 4:74-7(c) (1986).

6. Wis. Stat. Ann. § 51.20(12) (West Supp. 1985).

7. A national commission recently recommended that a task force be convened "to develop and disseminate recommendations on appropriate media portrayals of the mentally ill." National Commission on the Insanity Defense, Myths & Realities, Recommendation 8, at 40 (1983).

PART G
JUDICIAL DETERMINATIONS AND CASE DISPOSITIONS

Intense debate centers on the adjudicatory and dispositive factors that courts are legally obligated to consider in deciding whether a person is a proper subject for involuntary civil commitment.[1] Important among these factors are the elements that make up the standards for commitment, *viz*., mental illness, the likelihood that a respondent will cause harm to self or to others, the likelihood that the respondent may suffer substantial mental or physical deterioration, his or her lack of capacity to make informed decisions about treatment and care, the likely success of treatment, and the availability of alternatives to hospitalization.[2] The history of involuntary civil commitment in the United States in the last thirty years has been one of periodic calibrations of these legal "tests" for committability.

Departing from the tradition of other initiatives to reform involuntary civil commitment, the guidelines in Part G do not advocate a particular legal standard for commitment to be applied in all jurisdictions, but instead recommend the careful application of extant standards prescribed by state statutes. Two of the four guidelines in this part focus on the judicial determinations and dispositions of involuntary civil commitment cases that are made following a court hearing based on the legal standard for commitment. Guideline G1 attempts to shift lawyers' and mental health professionals' preoccupation with the wording of the standard for commitment to a broader, practical context, in recognition that the specific words of the legal standard are only a small part of the commitment process unfolding at a commitment hearing.[3] In Guideline G2, the National Task Force took the position that no particular disposition of a case involving a petition for involuntary civil commitment is *per se* superior to another, but that courts must consider all dispositional alternatives, including commitment to outpatient mental health treatment and care in lieu of institutionalization. However, although the theory of outpatient involuntary civil commitment has great appeal, the National Task Force urged caution in applying the theory, because it has yet to be tested. Like other legal concepts, its translation into fair and workable practices is problematic.[4] Clearly, involuntary civil commitment should not be synonymous with compulsory hospital-based care, but hospital-based care should not be considered always inferior to alternatives in the community, especially when those alternatives are inadequate.

Guideline G3 sets forth requirements for court orders. Because substantial liberty interests are involved in judicial orders for involuntary commitment, the guideline recommends that such orders should communicate as much information as possible regarding the site and the nature of involuntary treatment and care. Guideline G4, the last in this part, prescribes the procedures for making, retaining, and releasing the records of court hearings.

Notes

1. For a recent illustration of such debate, see the special issue of 36 Hosp. & Community Psychiatry 967-89 (1985) devoted to reactions by lawyers, mental health professionals, and a representative of family groups to the model commitment law proposed in 1983 by the American Psychiatric Association. This model law is discussed in Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 Harv. J. on Legis. 275 (1983). *See also* Roth, *Mental Health Commitment: The State of the Debate, 1980*, 31 Hosp. & Community Psychiatry 385 (1980).

2. See generally S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* ch. 2, Involuntary Institutionalization (3d ed. 1985).

3. The significance of any of the competing legal formulae turns not on whether any one formula is superior in abstract terms but rather on whether it actually leads triers of fact to admit more or less evidence or causes testimony by witnesses to be more or less useful. National Task Force members felt that rather than legal criteria poorly formulated by state legislatures, a more serious problem in involuntary civil commitment is that existing criteria are poorly understood, misconstrued, misapplied, or simply ignored in practice. This is not to suggest that the public debate and legislative deliberations about the proper standard for involuntary civil commitment have been without important consequences or that the wording of a legal standard for commitment may not have bearing on the commitment process. In Guideline G1, the National Task Force simply took note of the importance of the "law in practice" and looked beyond a formulation of *the* standard for commitment (*viz*., the "law on the books") as an important step toward improvement of judicial determinations and dispositions of commitment cases.

4. Involuntary outpatient commitment faces many of the same impediments that criminal probation programs encounter: unclear goals, inadequate funds, lack of staff, and inadequate resources for monitoring and supervising probationers in the community. *See* J. Petersilia, S. Kahan, & J. Peterson, *Granting Felons Probation: Public Risks and Alternatives* (1985); *see also* Commentary, Guideline H4, "Monitoring, Review, and Revocation of Involuntary Outpatient Status."

G1. Strict Application of Legal Criteria for Commitment

Economic and social pressures to use the involuntary civil commitment process to accomplish a wide range of social and regulatory objectives threaten the integrity of the process. Much of the threat stems not from the inadequacy of the present legal standards for involuntary civil commitment but rather from existing statutory standards that are poorly understood, misconstrued, misapplied, or simply ignored in practice, so that the commitment process is used for purposes for which it never was intended. Despite dire needs for mental health and other human services, involuntary civil commitment should not be the mechanism whereby scarce resources are thrust, without proper regard for the

legal grounds for commitment, upon persons unwilling to accept them. Such needs are best served by other formal and informal means. Misuse of civil commitment to meet the needs of persons to whom the process should not be applied will only undermine efforts to obtain services appropriate to meet those needs.

(a) The proper bases for determining whether a person is a fit subject for involuntary civil commitment are the legal criteria set forth in state statutes. They are the best available expression of the intent of a legislature regarding a state's involvement in coercive treatment and care. Those criteria should be strictly applied by officers of the court presiding over commitment proceedings. A court should not order involuntary civil commitment unless it finds by clear and convincing evidence that the legal criteria for commitment have been met.

(b) State statutes require, explicitly or implicitly, predictions about the likely course of a respondent's mental disorder and his or her future behavior with or without compulsory treatment and care. Such predictions, especially about future dangerous behavior, are difficult to make within acceptable levels of reliability and accuracy. In order to improve the appropriateness, accuracy, and reliability of clinical predictions about future dangerousness and related factors, such as mental deterioration, treatability, and competence to make treatment decisions, which must be established to satisfy involuntary civil commitment criteria defined by state law, clinicians called upon by the courts to make such predictions should take the following factors into account:

(i) whether the respondent recently has verbally or physically threatened, attempted to inflict, or, by recent overt acts of commission or omission, actually inflicted substantial physical harm upon himself or herself or others;

(ii) verifiable observations of events or behaviors of the respondent indicating that he or she is unable to provide for basic needs, such as adequate shelter, food, clothing, and hygiene;

(iii) precipitating events and situations, as well as the environmental and social contexts in which they took place;

(iv) relevant demographic characteristics of the respondent and history of mental disorder and dangerous behavior;

(v) the base rate of dangerous behavior among individuals of the respondent's background;

(vi) the sources of stress in the respondent's environment and the cognitive and affective factors that suggest the respondent may be unable to cope with that stress;

(vii) the similarities between the contexts, including any social and financial supports, in which the respondent has exhibited mental disorders or dangerous behaviors in the past and those in which the respondent must function in the future;

(viii) the availability and proximity of likely victims of the respondent's dangerous conduct;

(ix) the availability to the respondent of the means to contribute to his or her deterioration (e.g., alcohol) or to commit violence; and

(x) any issues of personal or professional ethics involved in the case that may influence the clinical predictions.

Commentary

Guideline G1 does not recommend specific substantive criteria for involuntary civil commitment for adoption by state legislatures. Consistent with the general aim of the National Task Force to develop guidelines for the fair and workable administration of existing state statutes rather than to construct "model" laws, it did not take a position on the specific formulation of a "test for committability" to be used in every jurisdiction. The guideline recommends, instead, the careful application of existing statutory standards for mental disorder or defect, dangerousness, grave disability, substantial mental and physical deterioration, treatability (including the availability of alternative modes of treatment and care), and competency to make treatment decisions. The guideline urges that particularly close attention be paid to predictions of future behavior, especially predictions of violence and assessments of dangerousness. Such predictions have been the bane of clinicians who admit limited professional competence to offer estimates of the future yet are mandated legally to do so. In recognition that such predictions will continue to provide a basis for involuntary civil commitment, even amid controversy about the scientific and technical shortcomings and the ethical dilemmas that surround them, paragraph (b) suggests that certain factors be taken into account to improve the appropriateness, accuracy, and reliability of predictions of future dangerousness.[1]

The National Task Force recognizes that the controversy and debate about the proper formulation of the substantive criteria for commitment will continue. Reasonable people will disagree about whether a particular statutory definition of dangerousness or substantial mental deterioration, for example, is good policy or workable law.[2] However, some members of the National

Task Force expressed concern that the calibration of a statutory standard for commitment may have been overemphasized[3] and due consideration of the conscientious administration of those criteria, underemphasized. Indeed, the overemphasis on the particular wording of commitment criteria may have prevented attention and valuable resources of the judicial-mental health system from being applied instead to improved procedure and practice.[4]

It is almost impossible to read accounts of deinstitutionalization, of the decline of state hospitals serving mostly the poor, of the growth of for-profit psychiatric hospitals designed mostly for the affluent, and of the effects of budget cuts in community mental health programs[5] without feeling some sympathy for those who must face the emotional and financial consequences of the lack of mental health and social services. Sympathetic and well-meaning judges, commissioners, referees, and other hearing officers faced with respondents who appear to need help and for whom there are few if any options available other than involuntary civil commitment understandably may feel compelled to make the determination that those respondents are fit subjects for commitment. However, although there may be no magical answer for a small number of respondents who may need some type of mental health intervention but who resist attempts to provide such care on a voluntary basis, it is inappropriate to use the leverage of involuntary civil commitment when there are inadequate grounds for commitment. Statutory intentions should not be thwarted toward the end of assuring services for persons in need. This does not mean, National Task Force members agreed, that judges and attorneys must stand helpless in the face of limited and inappropriate services. Instead, they should take seriously their ethical obligation to make sure that such services are provided to the maximum extent possible by taking leadership roles in their communities.[6]

Sympathy and compassion for the plight of mentally ill persons and their families are certainly to be encouraged, and inadequate mental health and social services cannot be ignored by individuals of good conscience. However, involuntary civil commitment is an inappropriate expression of such concerns. Using the leverage of commitment to secure needed services that may otherwise not be readily available, when no legal grounds exist for commitment, subverts the commitment process and, more importantly, undercuts pressure toward meaningful change. A judge or a referee has a responsibility to go against sympathy, compassion, and personal inclination to commit a respondent for humanitarian reasons and must adhere rigorously to commitment criteria and, if necessary, release a respondent who may have obvious needs. To do otherwise would undermine the commitment process. A judge or referee does not, however, discharge his or her responsibility simply by applying the commitment criteria to a particular case and ignoring the needs of the respondent. He or she should attend to those needs even when they do not meet the commitment criteria by encouraging the respondent to seek voluntary mental health care and related social services and by instructing the respondent's attorney to advise the respondent accordingly. To prompt appropriate responses by the mental health-justice system to similar cases in the future, the judge or referee could exert influence as a member of a community coordinating council or similar body.

Subversion of the involuntary commitment process may not be a new phenomenon,[7] but in the 1980s, with economic and social pressures threatening a breakdown of the social welfare system, there is a serious risk that involuntary civil commitment will be used for all kinds of purposes for which it never was intended. The inevitable pushes and pulls in mental health-law interactions (e.g., a loosening of involuntary commitment criteria, causing reductions in voluntary admissions)[8] will cause subversion of involuntary civil commitment and undercut pressures for change that address the needs of those who may not be appropriately dealt with by means of involuntary mental health services. In recommending strict adherance to existing legal standards for commitment, the National Task Force hoped to convey the importance of a thorough understanding of what involuntary civil commitment was designed to do, what its limits are, and what it can and cannot accomplish and to encourage compliance by judicial officers, mental health professionals, and law enforcement officers with the legal criteria established by legislatures for involuntary civil commitment.

In recent years, reforms have led to changes in the statutory criteria for civil commitment.[9] Some of these efforts have been in response to the lack of reliable, generalizable evidence that mental health professionals possess the expertise for predicting dangerous behavior and in response to questions regarding the propriety of mental health treatment facilities providing only custodial care, i.e., food, clothing, and shelter. Examples of proffered changes include detailed definitions of dangerousness, requiring recent behavior that threatens or causes serious bodily harm. Critics of such changes charge that a requirement of an overt act is overly restrictive. They argue that patients who allude to dangerous acts without making explicit threats or without actually engaging in explicitly dangerous behavior nevertheless may present a danger to themselves or others. To prohibit their involuntary commitment is to invite tragedy. The currently prevailing opinion, however, favors requiring recent behavioral evidence of dangerousness to enhance the accuracy of assessments of future dangerousness.

A criticism voiced about current commitment provisions is that they do not sufficiently distinguish among three elements of the involuntary commitment decision: the diagnostic element (Is the respondent really ill?), the predictive element (Is the respondent dangerous or unable to care for himself or herself?), and the prescriptive

element (What form of treatment is appropriate?). If the applicable statute fails to provide precise definitions, courts should develop criteria indicating the type of evidence necessary to demonstrate dangerousness or disability. Such evidence may be presented through the testimony of the petitioner or other witnesses. In addition, courts should encourage counsel to relate presented evidence to each of the three legal elements. In this regard, civil commitment cases should be treated like any other proceeding in requiring the plaintiff to establish the jurisdictional basis of the claim (i.e., that the respondent is mentally ill), the basis for liability (dangerousness or helplessness), and the basis for the relief being sought (the appropriateness of the proposed treatment). Although the question of whether a respondent's mental condition and circumstances satisfy a state's commitment criteria is difficult to separate from the question of the treatment and care that may or may not be appropriate, presentation of evidence, argument, and findings regarding the appropriate disposition should be distinguished from and not prejudice the determination regarding the respondent's eligibility for commitment.

To encourage a more ordered presentation of evidence in involuntary commitment proceedings, a court should not consider dispositional questions until after it determines that the respondent is eligible for commitment. The mixing of eligibility and dispositional evidence is often a source of confusion. It creates the possibility that a respondent may be committed because he or she needs services, even though he or she does not meet the legal criteria for involuntary commitment.[10]

Nothing in this guideline prevents initiation of the dispositional portion of the proceeding immediately upon the determination of eligibility. Because many of the witnesses who testified regarding the respondent's mental condition are likely to testify regarding treatment as well, considering the dispositional issues at once has definite advantages of efficiency and convenience. Some jurisdictions, however, may prefer to delay the dispositional hearing until a full treatment plan can be prepared. This would give the court the benefit of a more thorough assessment of the respondent's needs and of the available alternatives.

Must a respondent meet the commitment criteria at the time he or she is taken into custody, at the time of the hearing, or both? Current statutes provide little guidance concerning this question. If the respondent's condition at the time of the hearing is not considered, an individual who has recovered from an acute psychotic episode may be involuntarily committed even though he or she may no longer meet the legal criteria for commitment. If the respondent's condition prior to hospitalization is ignored, it will be impossible, in many cases, to present clear and convincing proof of dangerousness or disability. Thus, at the initial commitment hearing, the court should require the petitioner to establish that the respondent met the criteria for commitment at the time the proceedings were initiated and, further, that the respondent remains so mentally ill that he or she still would be dangerous to self or others, or unable to fulfill his or her basic needs, if treatment were not administered and he or she were released immediately.

Although most current statutes do not explicitly address which party has the burden of persuasion in an involuntary commitment proceeding, it is implicit that this burden falls on the petitioner, or the state on the petitioner's behalf.[11] If this were not so, the petition would be presumed true and the respondent would have to prove that he or she is not mentally ill, dangerous, or helpless. Such presumptions and negative proof requirements are not found elsewhere in American jurisprudence where matters of personal liberty are at issue, and they are particularly inappropriate in the mental health area.

Guideline G1 requires clear and convincing proof of prepetition conduct reflecting the respondent's inability to meet his or her basic health and safety needs. A petitioner would have to prove that the respondent's condition is a result of mental disease and that there is a substantial likelihood that, without treatment, the condition would continue. The guideline assumes that many individuals may suffer from chronic mental disabilities and may not be helped by currently available treatment methods. They require shelter and humane care, but not necessarily specialized mental health treatment. Community and institutional mental health facilities are a scarce resource that should not be employed merely for shelter care. Guardianship, rather than civil commitment, may be a more appropriate remedy for these individuals. It is anticipated that many such cases will be identified and diverted during the screening process.[12]

Notes

1. The ten factors described in Guideline G1, paragraph (b), are based upon prescriptions for the way in which mental health professionals should go about effectively assessing a person's potential for violence provided in J. Monahan's monograph *Predicting Violent Behavior: An Assessment of Clinical Techniques* (1981). Written to assist mental health professionals, the monograph is widely acknowledged as the most comprehensive review and discussion of the current scientific literature pertaining to the prediction of dangerousness. Chapter 6, *id*. at 43-171, which summarizes and synthesizes the factors and techniques that may prove helpful in conducting assessments of the potential for violence, is particularly recommended to the reader.

2. *Compare* Rubenstein, *APA's Model Law: Hurting the People It Seeks to Help*, 36 Hosp. & Community Psychiatry 968 (1985) *with* Stone, *A Response to Comments on APA's Model Commitment Law*, 36 Hosp. & Community Psychiatry 984 (1985).

3. *See, e.g*., Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, in American Psychiatric Association, *Issues in Forensic Psychiatry* 57, 115 (1984) (stating that the subsection setting forth the recommended criteria for commitment is the "heart" of the model law).

4. In the practice of law, just as in the practice of other professions or trades, it is often the mores and customs which deserve the attention usually paid to the written rules of substance and procedure. Although thousands of words are written about the subtle words of a significant court decision or statutory revision, usually limited analysis

> is given to what can be termed the "socialization of the law."

Perlin, *The Legal Status of the Psychologist in the Courtroom*, 4 Ment. Disability L. Rep., 4 (1980). *See also* A. Stone, *Mental Health and the Law: A System in Transition* 47 (1975) ("Worse yet, there is increasing doubt, spawned by research and practice in a wide array of fields, as to whether these criteria really mean anything at all."). A report of the evaluation of the Massachusetts Mental Health Reform Act of 1970 concluded that the "most profound statistical changes [associated with the implementation of the law] appeared to have been associated largely with procedural, rather than substantive, changes in the law." McGarry, Schwitzgebel, Lipsitt, & Lelos, *Civil Commitment and Social Policy: An Evaluation of the Massachusetts Mental Health Reform Act of 1970*, 139-41 (1981).

Despite evidence that major substantive changes in civil commitment laws may have had relatively little impact on practice, lawyers and mental health personnel continue to focus their energies on effecting changes in the substantive law. See I. Keilitz & B. McGraw, *An Evaluation of Involuntary Civil Commitment in Milwaukee County* 100-02 (1983). In response to a proposal to add a fifth criterion to the commitment standards of the Wisconsin Mental Health Act to allow the commitment of persons who are "obviously and seriously ill without a showing of dangerousness," these authors argued:

> Although the proposed edition of a fifth standard may merit consideration as a matter of substantive law, legislative reform is not recommended. At the present time, the resources of the mental health-legal community in Milwaukee County should be channeled into improvements of the practices in involuntary civil commitment proceedings under the current state mental health act rather than into seeking improvements by legislative reform . . . .
>
> We . . . strongly believe a major support aimed at legislative reform provided by Milwaukee's mental health-legal community will result in few practical changes and will also contribute to further unnecessary polarization of several forces within that community. In our opinion, it is the practices and procedures not necessarily expressly provided by statute — negotiated settlements, diversion to voluntary admission, crisis intervention, to name just a few familiar ones — that make the difference.

Id. at 101.

5. *See* Truit, *Data Watch: Data Show Threat of Two-Tiered Care in Mental Health*, 16 APA Monitor, December 1985, at 29.

6. For example, judges can exercise their leadership role as members of a community coordinating council and, thereby, can mobilize community support for "drop-in centers" and other needed measures. *See* Guideline A1, "Community Coordinating Council."

7. *See* Wexler, *The Structure of Civil Commitment: Patterns, Pressures, and Interactions in Mental Health Legislation*, 7 Law & Human Behav. 1 (1983).

8. *See* Durham, *Implications of Need-for-Treatment Laws: A Study of Washington State's Involuntary Treatment Act*, 36 Hosp. & Community Psychiatry 975(1985); *see also* Wexler, *supra* note 7, at 4.

9. Most state statutes provide that for an individual to be involuntarily committed, it must be shown that he or she is mentally ill and either is so gravely disabled that he or she is unable to provide for his or her basic needs or is a danger to himself or herself or to others. The precision with which these concepts are expressed varies considerably. Some statutes include only the term "dangerous" or "gravely disabled". *E.g*., Ind. Code Ann. §§16-14-9.1-9(c)(1), 16-14-9.1-10(d)(1) (Burns Supp. 1985); N.C. Gen. Stat. §122C-268(j) (Supp. 1985). Others require a showing of a threat, an attempt to inflict harm, or an actual incidence of harm being inflicted. Ariz. Rev. Stat. Ann. §36-501.3,-.4 (Supp. 1985); Wash Rev. Code Ann. §71.05.280(1) (Supp. 1986). A few require proof of additional matters, e.g., that the individual is likely to benefit from the proposed treatment, N.M. Stat. Ann. § 43-1-11-C(2) (1984), or that no less restrictive alternative exists, *e.g*., N.M. Stat. Ann. §43-1-11.C(3) (1984); Va Code §§37.1-67.3 (Supp. 1985).

A number of statutes require use of the "least restrictive alternative," that is, treatment in the setting and manner which impinge least upon an individual's liberty, freedom of choice, and bodily integrity while also accomplishing the appropriate treatment objectives. In some of these jurisdictions this requirement serves as a prerequisite for commitment. *See, e.g*., N.M. Stat. Ann. §43-1-11.C(3) (1984); Va. Code §37.1-67.3 (Supp. 1985); W. Va. Code §27-5-4(j)(2) (Supp. 1985). In others it is included among the criteria for determining the proper disposition after an individual has been found to be eligible for commitment. *E.g*., Ill. Ann. Stat. ch. 91 1/2, §3-811 (Smith-Hurd Supp. 1985); Mich. Comp. Laws Ann. ??330.1519 (West 1980); Ohio Rev. Code Ann. §5122.15(c)(Page Supp. 1984).

The inclusion of a least-restrictive-alternative requirement in the criteria for commitment presumes that commitment and institutionalization are synonymous. Although commitment and institutionalization formerly were considered synonymous in most jurisdictions, this is no longer so. Involuntary civil commitment encompasses not merely institutionalization but also the involuntary provision of mental health services in a variety of settings. Given this trend toward a broad definition of involuntary civil commitment and the provisions recommended above for providing an opportunity to consent to treatment, use of the least-restrictive-alternative principle as a threshold requirement appears unnecessary.

For a critical analysis of existing commitment criteria and use of the least restrictive alternative, see Hermann, *Barriers to Providing Effective Treatment: A Critique of Revisions in Procedural, Substantive and Dispositional Criteria in Involuntary Civil Commitment*, 31 Vand. L. Rev. 1 (1986). *See generally* S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* ch. 2, Involuntary Institutionalization (3d ed. 1985).

> 10. Regardless of whether the court and the parties, in fact, held this presumption, the questions of committability and treatment lost their independent significance in the hearings we observed. The discreteness of these two questions can be lost when the evidence presented concerning each is mixed with the presentation of evidence concerning the other. This was most apparent in the corporation counsel's presentation of expert witnesses. The expert testimony presented was that of the psychiatrist and psychologist appointed to examine the respondents. When each examiner was testifying, corporation counsel asked the examiner's opinion concerning whether the respondent was dangerous, whether the respondent was proper subject for treatment, and whether the examiner recommended the Milwaukee County Mental Health Complex as the proper facility for treatment of the respondent. Obviously, the first two questions address committability and the last addresses treatment. This is but one example of the mixing of the committability and treatment issues which we observed that may create not merely confusion of the issues, but also may create the possibility that a respondent might be found "committable" because he or she needs treatment and not because he or she meets the commitment criteria.

I. Keilitz & B. McGraw, *supra* note 4, at 94-95.

11. The United States Supreme Court concluded in *Addington v. Texas*, 441 U.S. 418 (1979), that

> [T]he individual's interest in the outcome of a civil commitment proceeding is of such weight and gravity that due process requires the state to justify confinement by proof more substantial than a mere preponderance of the evidence ... [but] that the reasonable doubt standard is inappropriate in civil commitment proceedings because, given the uncertainties of psychiatric diagnosis, it may impose a burden the state cannot meet and thereby erect an unreasonable barrier to needed medical treatment.

Id. at 427, 432. Accordingly, the Court adopted "a middle level of burden of proof that strikes a fair balance between the rights of the individual and the legitimate concerns of the state." *Id*. at 31. The Court held that the "clear and convincing" standard is the minimum standard which will meet due process guarantees. The precise level of proof, so long as it meets the minimum constitutionally required standard, is a matter of state law.

Prior to the *Addington* decision, many state statutes set clear and convincing proof or clear, cogent, and convincing proof as the level of certainty which must be attained before involuntarily committing an individual. A few states require proof beyond a reasonable doubt. *See, e.g*., Mass. Gen. Laws Ann. ch. 123, §8A(a) (West Supp. 1985) (for commitment to an intensive care unit for women); *Commonwealth v. Nassar*, 380 Mass. 908, 916, 406 N.E.2d 1286, 1290 (1980) (in all commitment cases, the state must prove substantive risk beyond a reasonable doubt); Hawaii Rev. Stat. §334-60.5(i) (Supp. 1984). In those jurisdictions in which the statutes still contain a preponderance-of-the-evidence standard, courts should recognize the constitutional mandate and require the petitioner or the state to present evidence meeting the *Addington* standard. Thus, a petitioner should present at least clear and convincing proof that the respondent is mentally ill, that he or she has engaged in conduct that demonstrates dangerousness or helplessness, and that if treatment were halted, there is good reason to believe that the respondent would still be dangerous or helpless. *See* S. Brakel, J. Parry, B. Weiner, *supra* note 9, at 67; Wexler, *Mental Health and the Law: Major Issues* 59-68 (1981).

12. *See* Part B, "Screening: Organization and Administration."

G2. Consideration of All Dispositional Alternatives, Including Outpatient Commitment

Involuntary civil commitment is not necessarily synonymous with institutionalization. Compulsory hospitalization should be considered along with other available dispositional alternatives, including commitment to outpatient mental health facilities and other human services agencies. Consideration of all alternatives between institutionalization and absolute release, as well as disposition of a case based on such consideration, is provided in most state statutes and is, arguably, required by the Constitution.

(a) Involuntary outpatient commitment, whereby a court orders mental health care and related social service in lieu of institutionalization, should be used cautiously, because its goals are questionable and its implementation is problematic. Administration of involuntary outpatient commitment as part of a general civil commitment scheme requires much more of the mental health-justice system than was required in times when a court order to commit invariably meant institutionalization. It requires, most importantly,

(i) careful selection of potential involuntary patients in accordance with the applicable legal criteria and prerequisites for outpatient commitment (only some involuntary patients will have the ability to follow a mental health treatment plan in the community);

(ii) commitment courts that are thoroughly familiar with the continuum of services available in the community;

(iii) available alternatives to hospitalization that meet the legal, fiscal, and practical requirements of outpatient commitment orders;

(iv) adequate resources for respondents' supervision while in outpatient status;

(v) organizational arrangements and procedures for the monitoring and review of the respondent's compliance with the conditions of outpatient commitment; and

(vi) fair and workable rules and procedures for revoking outpatient commitment when necessary.

When these requirements are met, involuntary outpatient commitment can be beneficial to respondents who require compulsory treatment outside of a hospital setting and care, respondents who would otherwise be forced into institutional care.

(b) After determining that there are sufficient legal grounds for commitment, judges and other nonjudicial hearing officers should give due consideration to all dispositional options between outright release and compulsory hospitalization — including all mental health and social interventions along the continuum of services in the community — and impose that option consistent with the "least restrictive alternative" doctrine which will achieve appropriate treatment and care goals.

(c) Involuntary outpatient care and treatment or other dispositions of a commitment case in lieu of hospitalization may be initiated by a commitment court — as a matter of established law or under its inherent authority — by a formal court order for involuntary outpatient commitment or by other procedures achieving the same ends, e.g., court order of involuntary civil commitment followed by a stay of the execution of the order under conditions for the care and treatment of a respondent in a setting other than a hospital.

Commentary

Involuntary civil commitment is no longer synonymous, at least theoretically, with the placement of a respondent in a maximum-security ward of a state mental hospital for an indeterminate period of time. Techniques and settings available to assist mentally ill individuals outside of hospitals are increasingly available. Because of these alternatives to institutions, because of the constitutional mandate that the nature and duration of a commitment must bear a reasonable relationship to

the purpose of the commitment,[1] and because a state may not impose any greater restrictions on fundamental freedoms than are necessary to serve a legitimate state interest,[2] legislatures and courts increasingly have recognized and applied the doctrine of the "least restrictive alternative."[3]

The least restrictive alternative in involuntary civil commitment proceedings is the combination of therapeutic and preventive interventions provided by mental health and social service providers, judges, attorneys, law enforcement personnel, and others, including the respondent and the petitioner, that (a) is conducive to the most effective and appropriate treatment and care that will give the mentally disordered person a realistic opportunity to improve his or her level of functioning and (b) is no more restrictive of a person's physical, social, or biological functioning than is necessary to achieve legitimate state purposes of protecting society and providing mental health treatment and care. In balancing the interests of the individual, his or her family, and the state, a determination of less restrictive alternatives must consider and weigh a number of factors, including the environmental restrictiveness of the treatment setting; the psychological or physical restrictiveness of behavioral, chemical, or biological treatments; clinical variables, including the person's behavior as it relates to the legal criteria for involuntary civil commitment; the relative risks and benefits of treatment alternatives; the family and community support available in the person's environment; the quality or likely effectiveness of the alternative care and treatments; the duration of treatment; the likelihood that a person may pose a risk to public safety; the availability, cost, and accessibility of alternative treatment and care; the likelihood of the person's cooperation or compliance with the conditions of alternative treatment programs; and mechanisms for monitoring and reviewing that compliance.

This definition of the least restrictive alternative presumes that the doctrine is not reducible to a concrete set of operations applicable to every respondent.[4] Attempts to apply this open-ended construct in mental health law by articulating a "magical calculus"[5] that uniformly would govern the least restrictive alternative determination in every case seem unreasonable.[6] A wide gap exists between the theoretical demands of the doctrine and the harsh realities of its application.[7] The above definition attempts to bridge that gap by requiring a case-by-case determination of the least restrictive alternative and by specifying factors to be weighed in each determination. These factors are not intended as elements of an all-encompassing test whose proper application will determine the placement or treatment decision in every case. Rather, they are factors to be considered in each decisionmaker's exercise of clinical or legal judgment. Thus, two different decisionmakers might reach differing conclusions in the same or similar cases. A later decisionmaker may disagree with an earlier decisionmaker's assessment because of additional information accumulated through screening or examination of the respondent. For example, a mental health screening officer who lacks medical training (e.g., a psychologist or social worker) may conclude that involuntary inpatent hospitalization is necessary, but an examining psychiatrist may determine that medication administered on an outpatient basis would be sufficient to treat a respondent.

These factors are important to the decisionmaking process to ensure that each decisionmaker, to the extent of his or her expertise or of the available information, attempts to identify the least restrictive alternative. Some decisionmakers, however, may have insufficient information or expertise to apply all of the factors. It may be necessary to reserve judgment for a later decisionmaker who can draw upon further screening to determine the least restrictive alternative. Alternatively, a decisionmaker may seek advice from someone with the expertise to apply a particular factor.

The factors articulated in the definition are important to the decisionmaking process, but do not necessarily dictate the conclusion to be reached based on their application. The least restrictive alternative in a particular case should be determined in the context of the respondent's condition, treatment needs, and preferences. Restrictiveness should not be determined based only on the inherent qualities of the mode of treatment.[8] "[T]reatments are more or less restrictive according to the needs of the patient for whom they are employed: an unnecessary treatment is always highly restrictive, but the restrictiveness of an *indicated* modality varies with the degree of freedom it is likely to restore to the patient who receives it."[9]

If the least-restrictive-alternative doctrine is to become a reality, involuntary civil commitment cannot be synonymous with inpatient hospitalization. The commitment court should exercise flexibility and impose treatment and care appropriate to the respondent's condition and circumstances. Judges and nonjudicial hearing officers should consider all possible and appropriate dispositions of a case lying between the unconditional, immediate release of a respondent and immediate hospitalization.

Guideline G2 calls upon the court to select the least drastic means available for achieving the treatment objectives. This does not mean that the judge must decide the appropriate dosages of psychotropic medications or the intensity of therapy. Rather, it requires the court to consider the types of settings (e.g., maximum security ward, nonsecure ward, outpatient community mental health care) and the broad classes of therapy and services proposed and to select those that best address the respondent's needs and problems and that intrude least upon the respondent's freedom of action and bodily integrity.[10]

Strictly speaking, involuntary outpatient commitment is the dispositional option lying between inpatient

hospitalization and outright release that is available to a court after an evidentiary hearing and adjudication of involuntary civil commitment (i.e., the judicial determination that a person meets involuntary civil commitment criteria). Involuntary outpatient commitment is to civil commitment as probation is to criminal conviction. Instead of ordering a person's confinement in an institution or, ultimately, release from detention or custody, the court orders the person to submit to some type of mental health treatment or care, or social services, in the community.[11]

Dispositional options lying between the extremes of institutionalization and outright release of a respondent have not been used by courts in most jurisdictions, although virtually all of the states permit those options to be used.[12] Recognizing strong reasons for not equating involuntary civil commitment with institutionalization, Guideline G2 urges the cautionary use of less restrictive alternatives to compulsory hospitalization, such as involuntary outpatient commitment, whenever such use is appropriate. Caution is urged, because the translation of the prescription of involuntary outpatient treatment and care, like the translation of other legal concepts,[13] into fair and workable procedures is fraught with difficulties.

Most of these difficulties are practical in nature, stemming from the sharp differences between (a) commitment to self-contained institutions, where the court vests complete responsibility for all treatment decisions and supervision in professionals in those institutions, and (b) commitment to fragmented community-based facilities with limited capabilities for case management and supervision, treatment monitoring, review of compliance with court requirements, and so forth. Difficulties include, but are not limited to, the following:

(a) uncertainties about whether local laws authorize court orders to involuntary mental health care and related social services in the community;

(b) serious questions of policy and practice regarding the obligation of community-based mental health facilities and programs to accept involuntary patients ordered to undergo outpatient treatment and care by a court;

(c) limited resources for the creation and development of organizational structures and procedural mechanisms and for the supervision of outpatients and the monitoring of their compliance with the conditions of an involuntary outpatient commitment order;

(d) the lack of clear standards and procedures for certifying or proving a respondent's failure to comply with an outpatient treatment program; and

(e) the lack of clear procedural mechanisms whereby commitment courts and mental health authorities could impose remedies for a respondent's noncompliance with a court order for outpatient commitment.[14]

Some of the difficulties likely to be encountered in the administration of involuntary outpatient commitment are political, attitudinal, and administrative, including (a) community resistance to outpatient commitment of respondents perceived to be a risk or an annoyance to the community, (b) the fear that outpatient commitment "widens the net" of state control over mentally ill persons, and (c) concern about the high costs of an efficient system of outpatient treatment supervision that would rival the criminal probation system.

Is the goal of involuntary outpatient care to provide more humane involuntary mental health care consistent with the least-restrictive-alternative doctrine, or is it to make it possible to impose coercive treatment and care upon those who would otherwise not be subject to involuntary civil commitment? Some members of the National Task Force expressed concern that involuntary outpatient commitment would be applied not primarily to those respondents who would otherwise be institutionalized but, instead, to those who would not be subject to state intervention in their lives if outpatient commitment were not available.

The question of whether outpatient involuntary civil commitment "widens the net of social control" is, quite simply, an empirical question. That is, given a base rate of civil commitments to institutions in a particular jurisdiction, does the use of commitments to outpatient care and treatment increase the total number of respondents committed? If commitments increase, a further question that must be asked is whether this increase is associated with decreases, increases, or stability in the rate of commitments to institutions. Unfortunately, few empirical data addressing these questions directly are currently available.

When a receiving community-based facility has had little input into the outpatient commitment decision, it is understandable that clinicians at the facility may deem the outpatient commitment inappropriate. The results of one study of sixty-seven outpatient commitment cases in North Carolina indicated that the courts had ordered outpatient treatment against the recommendations of clinicians at both state mental hospitals and the receiving community mental health centers.[15] Reportedly, judges ordered outpatient commitment without first determining, as state law required, that the recommended treatment and care were appropriate and available. The four judges in the jurisdictions studied decided to order outpatient commitment "simply because they felt that there was not quite enough evidence to support the recommendation for inpatient commitment from the [hospital] physician and they saw outpatient treatment as a less restrictive alternative to inpatient commitment."[16]

Notes

1. *See O'Connor v. Donaldson*, 422 U.S. 563 (1975); *Jackson v. Indiana*, 406 U.S. 715 (1972).

2. *See Shelton v. Tucker*, 364 U.S. 479 (1960); *Lake v. Cameron*, 364 F.2d 657 (1966).

3. The least-restrictive-alternative doctrine was most clearly expressed in Shelton v. Tucker, 364 U.S. at 488 ("[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. The breadth of legislative abridgement must be viewed in the light of less drastic means for achieving the same purpose." (footnotes omitted)). The doctrine was first applied in mental health litigation six years later, in *Lake v. Cameron*, 364 F.2d at 660 ("Deprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection." (footnote omitted)). Since Lake, application of the doctrine has been one of the strongest trends in mental health law. *See* Hoffman & Foust, *Least Restrictive Treatment of the Mentally Ill: A Doctrine in Search of Its Senses*, 14 San Diego L. Rev. 1100, 1101 (1977); Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 Mich. L. Rev. 1107 (1972). State and lower federal courts throughout the country have recognized the doctrine in mental health litigation, and all but three state legislatures have enacted statutes that require, in some form, that mental health treatment be administered in the manner or setting least restrictive of personal libery. McGraw & Keilitz, *The Least Restrictive Alternative Doctrine in Los Angeles County Civil Commitment*, 6 Whittier L. Rev. 35, 37 (1984). *See also* Keilitz, Conn, & Giampetro, *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 St. Louis U.L.J. 690, 695 (1984) (tracing the development of the least-restrictive-alternative doctrine and similar concepts from their philosophical roots, through their development in legislation and court rulings and, finally, to their application in practice).

4. Viewing the doctrine as an open-ended construct rather than a strict set of rules leads to a better understanding and application of the doctrine. *See* R. Roesch & S. Golding, *Competency to Stand Tria*l (1980): "[T]o infer competency is to engage in a complex process of judgment that is situationally dependent upon the facts of the instant case, but is not completely reducible to a set of rules about those facts." *Id*. at 13 (emphasis omitted). For examples of other definitions of the least restrictive alternative, *see* Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, 20 Harv. J. on Legis. 275, 291 (1983); *Suggested Statute on Civil Commitment*, 2 Mental Disability L. Rep. 127, 131 (1977). This suggested statute calls for a balancing of a variety of factors that are related to one another and cannot be viewed in isolation. The duration of treatment, for example, has obvious bearing on the restictiveness of the therapeutic setting and the psychological and physical restrictiveness of the prescribed treatment modality. But although most would agree that the longer the treatment, the more restrictive it is, there may be no agreement, except on a case-by-case basis, on how duration relates to the treatment environment on a scale of restrictiveness (e.g., short-term intensive inpatient treatment with psychotropic medication versus long-term commmunity-based care). *Cf.* Gutheil, Appelbaum, & Wexler, *The Inappropriateness of "Least Restrictive Alternative Analysis" for Involuntary Procedures with Institutionalized Mentally Ill*, 11 J. Psychiatry & L. 7, 10-15 (1983).

5. Hoffman & Foust, *supra* note 3, at 1152.

6. Such attempts are criticized in Gutheil, Appelbaum, & Wexler, *supra* note 4, at 7. These include establishing a restrictiveness scale, in which specific elements of a treatment modality are assigned scores, *id*. at 9-11 (discussing Ransohoff, Zachary, Gaynor, & Hargreaves, *Measuring Restrictiveness of Psychiatric Care*, 33 Hosp. Community Psychiatry 361-66 (1982)); assuming a specific relationship between restrictiveness and treatment effectiveness, *id*. at 12 (citing, with agreement, Hoffman & Foust, *supra* note 3); and constructing a hierarchy of restrictiveness, *see* McGraw & Keilitz, *supra* note 3, at 56-58, 63-65 (analyzing mental health conservatorship procedures in Los Angeles County).

7. Hoffman & Foust, supra note 3, at 1138; Keilitz, Conn, & Giampetro, *supra* note 3, at 712. Shah, *Legal and Mental Health System Interactions: Major Developments and Research Needs*, 4 Int'l J.L. & Psychiatry 219, 254 (1981) ("[W]hile the legal doctrine prescribing use of the `least restrictive alternative' has fairly clear meaning in reference to certain legal and constitutional values concerning infringement of personal freedom and liberty, the notion does *not* translate readily into mental health procedures and programs.") (emphasis in original).

8. Gutheil, Appelbaum, & Wexler, *supra* note 4, at 12.

9. *Id*. (emphasis in original).

10. Implementation of Guideline G2 could be modeled after the procedures established for providing special education services to eligible handicapped students in accordance with the requirements of the Education for All Handicapped Children Act of 1975. Education for All Handicapped Children Act, P.L. 943-149, 89 Stat. 775 (1975) (codified as amended at 20 U.S.C. §§ 14400-1461 (1976 & Supp. 1980)). First, a student must be found eligible to receive special education services by meeting established criteria. This determination is made after administrative review at a formal meeting of which the student's parents are given notice. The review and determination of eligibility are usually based on at least some consideration of possible educational approaches to be taken with the student. If the student is found eligible for special education, his or her placement is considered in view of the entire hierarchy of services for special education programs, ranging from hospitals and treatment centers to "mainstreaming" in a regular classroom. *See* A. Kirk, *Educating Exceptional Children*, 30-34 (2d ed. 1972); Keilitz, Conn, & Giampetro, *supra* note 3, at 697-700. The placement decision is made, once again, at a formal meeting of school administrators, teachers, and parents. Once a student is placed in an appropriate educational setting, any change in placement is subject to a number of procedural safeguards provided by the Education for All Handicapped Children Act, including a due process hearing before a local hearing officer.

11. It is important to distinguish involuntary outpatient commitment from other coercive procedures that may achieve the same ends. These procedures include (a) conditional or provisional release from an institution, (b) guardianship, and (c) protective services. The distinction between involuntary outpatient commitment and conditional or provisional release procedures lies in the decisionmaking authority (court versus treatment facility), the stage in the involuntary civil commitment proceedings where the procedures are used (after judicial hearing versus after a period of hospitalization and after adjudication and disposition by a court), and the legal authority of the disposition (commitment ordered by a court versus release with conditions by mental health personnel). Most states authorize hospital officials to provide treatment and care to an involuntary patient in the least restrictive setting, which may include conditional or provisional discharge to community-based care, even though a court has committed a person to an institution. *See, e.g.*, Minn. Stat. Ann. §253B.15(1) (West 1982) (the head of the treatment facility may provisionally discharge any patient committed as mentally ill, mentally retarded, or chemically dependent without discharging the commitment); *see also Bailey v. Noot*, 324 N.W.2d 164 (Minn. 1982). Involuntary outpatient commitment, in contrast, is ordered by a court (rather than authorized by mental health officials) before a person is committed to an institution. The result of involuntary outpatient commitment is, of course, identical to the actual consequences of conditional or provisional release of a person from the hospital, especially when such release is granted within a short period of time after a court has ordered the person to inpatient care.

Some jurisdictions have instituted procedures very similar to involuntary outpatient commitment except that the court causes the respondent to receive outpatient care *without* the issuance of a formal commitment order under conditions for the care and treatment of the respondent in an outpatient setting. In Minnesota, for example, after a hearing on an involuntary civil commitment but before a commitment order has been issued, the court may release the person into the community with conditions to guarantee the person's treatment and care in the community. The court may only revoke such a release after notice and a hearing. Minn. Stat. Ann. § 253B.09 (4)(West 1982). The conditions for outpatient treatment and care may have been set as a result of a settlement conference or prehearing conference. Though not specifically authorized or required by Minnesota statute, these settle-

ment conferences are available upon request of any party involved in commitment proceedings in Minnesota. W. Henschel, *Civil Commitment Court Proceedings*, in *Civil Commitment in Minnesota* 183 (Advanced Legal Education, Hamline University School of Law, 1985).

The law and practices of guardianship have evolved to provide for the appointment of substitute decisionmakers in cases where the personal or financial interests of incapacitated (not necessarily mentally ill or dangerous) individuals require protection. Generally speaking, guardianship proceedings are poorly suited to the purpose of providing compulsory community-based treatment for mentally ill persons. As a practical matter, a guardian would be unable to force a person to undergo treatment if a person refused. In such a case, the guardian probably would have to invoke the involuntary civil commitment process to effectuate compulsory treatment.

Modeled after the child protective service and child abuse reporting laws, which were adopted throughout the country during the 1960s, protective services statutes are designed to protect persons incapable of protecting themselves from abuse, neglect, or exploitation. As with guardianship laws, the provisions and procedures of protective services statutes are not responsive to the special needs of the mentally ill requiring some type of compulsory treatment and care, though they may achieve the same results as involuntary outpatient commitment.

These procedures — guardianship, protective services, and conditional or provisional release from compulsory hospitalization — are distinct from involuntary outpatient commitment as a matter of law and application. Despite the fact that they may be invoked for the protection and treatment of mentally disordered persons, with similar results, it is important to differentiate them from involuntary outpatient commitment as a distinct body of involuntary commitment law and practice.

12. *See* Keilitz & Hall, *State Statutes Governing Involuntary Civil Commitment*, 9 Mental & Physical Disab. L. Rep. 378 (1985).

13. *See* Shah, *supra* note 7, at 255-56.

14. *See* Commentary, Guideline H4, "Monitoring, Review, and Revocation of Involuntary Outpatient Status."

15. *See* Miller, *Involuntary Commitment of the Mentally Ill in North Carolina: A Physician's View*, Popular Government, Spring 1983, at 34.

16. *Id*. at 36.

G3. Court Order

At the conclusion of a hearing, the commitment court should communicate to the respondent, by written order and by an oral explanation, as much information about the nature and consequences of its decision as may be available at the time of the order for involuntary commitment or release. Further, attorneys representing the respondent and the state or the petitioners should explain the court order and its likely effects to their respective clients.

(a) A commitment order should indicate the legal grounds upon which the commitment is based, the general types of services and treatment to be provided, the place where those services are to be provided, the length of commitment ordered, whether the services and treatment are to be provided on an inpatient or outpatient basis, and the dates on which the court will examine the treatment plan and review the commitment. Judicial commitment orders to inpatient care should not be phrased so as to preclude consideration by treatment providers of the least restrictive treatment setting within an inpatient facility.

(b) To alleviate any confusion associated with the legal proceedings and to assure that the respondent does not leave the hearing unaware of what has occurred and why, the attorney should confer with the respondent within a reasonable time after the hearing and explain the terms of the court order. The attorney representing the state should confer with the petitioners to explain the court's order and its effects. Members of the treatment team and other representatives of the treatment facility should make themselves available to assist the attorneys in explaining the nature of the treatment and care to be administered in response to the court order.

Commentary

The purpose of Guideline G3 is to clarify the outcome of the commitment proceeding for the respondent, the petitioner, and the mental health and social service providers affected by a court order. It calls for the court to specify the criteria for involuntary commitment that have been met, what types of services and treatment are to be provided and for how long, who is responsible for providing them, and whether the respondent will be hospitalized or treated in the community. So that the parties are aware of what has occurred and what is to come, and to avoid the possibility of the parties leaving the proceeding without knowing either the nature or the consequences of the court's determination, the guideline requires that attorneys explain the commitment order to the parties at the close of the hearing, with the assistance of mental health professionals.

Although commitment courts and attorneys should always communicate clearly the nature and consequences of the commitment order to all parties, detailed written court orders may impede or prevent mental health professionals from providing the care to a respondent that is required when they feel that they must deviate from the precise terms of a court order. For example, treatment staff may feel that they would be in contempt of court if they alter a respondent's treatment plan without express approval of the court.[1]

The National Task Force recognized that detailed court orders can cut both ways for a respondent. On the one hand, detailed orders may serve to protect a respondent's liberty interest by limiting abuse of discretion by mental health professionals charged with the respondent's involuntary treatment and care. On the other hand, detailed court orders may serve to impede needed services that are in the respondent's best interest. Difficulties of detailed court orders may be exacerbated by division between the facility where a respondent has been detained pending a court hearing and the facility to which a respondent has

been committed.[2] In such instances, the staff of the "holding" facility may be largely responsible for preparing a treatment plan that subsequently must be implemented by a different, "receiving" facility. The latter may object to major elements of the plan. At the extremes, the preparation of a court order consistent with Guideline G3 seems relatively straightforward. On one extreme, a court order should not mandate aspects of daily management of involuntary mental health treatment that fall squarely within the responsibility of the treatment facility. For example, an order should not specify the types and dosages of psychotropic medications to be administered to a respondent. To do so would thrust the court into the untenable position of making clinical decisions, which it is ill-equipped to make, while seriously undermining the decisions of the treatment facility staff. On the other extreme, to leave a respondent completely in the dark with regard to what will happen to him or her flies in the face of the spirit of the legal protections afforded the respondent during commitment proceedings. Within these extremes, the detail provided in a court order cannot be prescribed except on a case-by-case basis. The best that a commitment court can do is to tell a respondent all that is possible to know about his or her involuntary care without impeding the actual delivery of that care.

Guideline G3 urges that the commitment court, which may have contemplated less restrictive alternatives before commitment or as part of a commitment order to outpatient care, not preclude the application of the least-restrictive-alternative doctrine by its phrasing of the court order. Notwithstanding the foregoing discussion of the pros and cons of detailed court orders, courts should consider the continuum of involuntary mental health services available and not foreclose the opportunities to use any of the services on the continuum once the order has been issued. More importantly, clinical staff should apply the least-restrictive-alternative doctrine in all of their plans for treatment of the respondent in the hospital.[3]

Notes

1. For example, if a court commits a respondent to the maximum security unit of a hospital for a specific period of time, hospital staff may be in a quandary about the extent of their authority to deviate from the court order. Do state statutes require the staff of treatment facilities to abide by court orders, or, in recognition of the nature of severe mental illness and the likelihood of wide fluctuations in a respondent's condition, do they allow discretion to modify treatment plans without court approval? If a hospital has several security levels, do treatment staff assume that a commitment court made an informed decision to commit to the maximum security unit even if the order is arguably improper from the perspective of good care? Some members of the National Task Force reported that mental health professionals faced with these questions may often find it easier to simply discharge a respondent, perhaps prematurely and without a court order, rather than face contempt charges if they transfer a respondent from a maximum security ward to a minimum security ward in the absence of explicit court approval. *See generally* S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law*, ch. 4, Discharge and Transfer (3d ed. 1985).

2. *See id*. at 203-205.

3. *See* Commentary, Guideline G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment." *Covington v. Harris*, 419 F.2d 617 (D.C. Cir. 1969).

> It makes little sense to guard zealously against the possibility of unwarranted deprivations prior to hospitalization, only to abandon the watch once the patient disappears behind hospital doors. The range of possible dispositions of a mentally ill person within a hospital, from maximum security to outpatient status, is almost as wide as that of dispositions without.

Id. at 623-24.

G4. Court Records

An accurate record is as important in involuntary civil commitment proceedings as it is in other legal proceedings. However, because of the sensitive nature of the information contained in that record, the confidentiality of court records should be protected by the courts.

(a) A stenographic or electronic recording should be made of all commitment hearings.

(b) The respondent's counsel should have access to, and the right to photocopy, all court records relating to the commitment proceeding.

(c) Court records of involuntary civil commitment proceedings should be closed. They should be opened only by permission of the respondent, his or her counsel, by court order to the attorney for the state, or by court order for purposes of research and program evaluation authorized by the court (see Guideline A3).

Commentary

Guideline G4 recommends that accurate records of commitment proceedings be made and that their confidentiality be protected by the commitment court. The availability of a record is essential to a respondent's ability to appeal a commitment order.[1] The guideline urges, in paragraph (a), that a stenographic or electronic record be made of all testimony, objections, arguments, instructions, and orders at involuntary commitment hearings and, in paragraph (b), that the record be accessible to the respondent's attorney. The guideline does not require preparation of an actual transcript of the hearing unless requested by one of the parties.[2]

Although accurate and complete records are needed for the effective operation of the court system, such records "can often outlast their usefulness and may gain unwarranted credibility and importance by reason of their very existence rather than their accuracy and relevance."[3] To lessen the risk to respondents that discrimination and stigma will result from unproven allegations,[4] paragraph (c) of the guideline recommends closing court records of an involuntary civil commitment proceeding and opening them only at the request of the respondent or by

court order. This will reduce the risk that the allegations and information contained in the court file will be misused.

By allowing researchers access to court records of commitment proceedings, the guideline reinforces the National Task Force's strong support of research and program evaluation expressed in Guideline A3, "Research and Program Evaluation."[5] Although improvement of involuntary civil commitment can be achieved through the appeals process,[6] such improvement necessarily focuses on the substantive and adjective or procedural categories of law, and not on the law in practice. Many questions of policy and law, and matters concerning the day-to-day administration of policies and laws, can only be addressed with empirical data. Unfortunately, many of the reforms of mental health laws, including those governing involuntary civil commitment, have been based largely on untested assertions and polemics instead of on actual experience and experimentation resulting in "hard" data. As is true with other mental health-law interactions,7 the public policies regarding involuntary civil commitment generally have not been guided by experience and the results of experimentation.

Most current mental health codes fail to address the length of time that court records of involuntary commitment hearings should be retained. Reports and other evidence, interim orders, and clerk's entries must be retained as long as a respondent remains subject to legal controls. If a commitment petition is dismissed, however, either because the respondent has consented to voluntary admission or because the court has found that the commitment criteria are not met, the need to maintain court records decreases. When a petition for involuntary civil commitment is denied or dismissed, a respondent may, because of the possible stigma attached to him or her as a result of the commitment proceedings, seek to have the court records of the commitment proceedings expunged. Such expungement of court records is not advised unless the records are the result of illegal actions preceding the denial or dismissal of the commitment petition.[8] The policy recommended by Guideline G4 of restricting and controlling access to the court records should protect respondents from misuse of information contained in the records.

Notes

> 1.[Failure to make a record] may be . . . to saddle the reviewing process with the burden of attempting to reconstruct a record and to impose upon the . . . [j]udge the unseemly duty of testifying under cross-examination as to the events that transpired in the hearings before him.

In re Gault, 387 U.S. 1, 58 (1967).

2. Although the National Task Force held to the principle expressed in Guideline G4 that the respondent should have access to the record of the commitment proceedings, members agreed that a free trial transcript should only be provided to an indigent respondent who wants to appeal an involuntary commitment order. *See Conservatorship of Waltz*, 167 Cal. App. 3d 835, 213 Cal. Rptr. 529 1985 ("Common sense dictates appointed appellate counsel cannot act on [a person's] behalf without a transcript of the trial proceedings.").

3. American Bar Association Commission on the Mentally Disabled, *Guardianship and Conservatorship*, 158 (1978)(footnote omitted).

4. For example, questions may arise concerning disclosure of court records to security firms or prospective employers of the respondent. *See* Appelbaum, Confidentiality in Psychiatric Treatment, in L. Grinspoon (ed.), Psychiatry 325 (1982); S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* ch. 10, Provider-Patient Relations: Confidentiality and Liability (3d ed. 1985).

5. Although the National Task Force urged research of involuntary civil commitment in all jurisdictions, members acknowledged that courts' reviews of research proposals may entail some expenditures of resources and that some courts may experience some difficulties in differentiating legitimate requests from those that would warrant the their disapproval. The only criterion for opening court records should be assurances that the respondent's confidentiality will be protected. Although some courts may wish to use other criteria for screening research requests, the National Task Force took no position and voiced no preference for types of research or program evaluation, proposed affiliations of researchers (e.g., university, consulting firm, and newspaper), research design, and other factors. *See* Guideline A3, "Research and Program Evaluation."

6. *See* Commentary, Guideline H1, "Posthearing Duties of Respondent's Counsel."

7. *See* Keilitz, *Reforming and Researching the Insanity Defense*, in *Mental Health Law in the 1980s* (A. Brooks & B. Winick ed.) (in press).

8. See Johnston v. State, 466 So.2d 413, 414 (Fla. Dist. Ct. App. 1985) (records cannot be expunged because "there is no basis on which this Court can find falsehood or perjury or even ill notices by any of the persons involved in this entire matter").

PART H
POSTHEARING PROCEDURES

Thirty years ago, once a commitment court determined that a person was a fit subject for commitment and the doors of the mental hospital closed behind him or her, whatever legal machinery had been working to protect the respondent's and the public's interests in civil commitment typically came to a virtual standstill. Subsequent authority for the respondent's compulsory treatment and care was vested with the professional staff of the hospital. There was little need for the court to consider alternatives to hospitalization and to review treatment plans — long-term institutionalization was the usual treatment. The person's mental condition was considered static by the law. If his or her condition did change, hospital authorities had the discretion to release the respondent or ease him or her gradually back into the community, without the approval or knowledge of the legal system. The process of commitment was fragmented and disconnected, even when it achieved admirable ends. Problems associated with these practices persist today.

The focus of Part H is on the legal review of a respondent's involuntary patient status and on the actions taken by lawyers and courts, in cooperation with mental health and social service providers, following a court hearing. The four guidelines in this part are premised on the commonsense notion that involuntary civil commitment should be a connected process from start to finish. They place additional responsibility on a respondent's legal counsel to assure that a respondent is treated well and that his or her rights are respected by treatment providers.

Despite the appeal of the "least restrictive alternative" doctrine, its translation into practice has been slow and difficult.[1] Thinking has outdistanced practices. To determine whether a respondent is a proper subject for commitment to outpatient care, a commitment court may need to consider such factors as the respondent's diagnosis and prognosis, treatment plans, and the concordance of a number of placement options with the interests of the respondent and the public, factors which did not require consideration thirty years ago, when a respondent was either in or out of an institution.

Courts may be resistant to, and understandably uncomfortable with, making what they feel are clinical decisions. For example, they may be unwilling to order outpatient commitment without assurances from the staff of the receiving facility that the conditions imposed by the commitment are reasonable and that there are adequate resources to implement the program of outpatient commitment.[2] Statutory provisions for revocation of outpatient commitment status notwithstanding, courts may be unprepared to do anything if those assurances are not there.

Indeed, the courts' role in commitment cases may have been more clearly defined and the determinations that they needed to make may have been much easier thirty years ago, when dispositional options were limited to unconditional release and institutionalization.[3] Today there are other options, requiring greater flexibility and fewer, less "once and forever" decisions by courts, as well as a continuing involvement of lawyers in the commitment process. Accustomed to closing cases at discrete points in legal proceedings, lawyers understandably may resist a continuing responsibility for a client served by a variety of disconnected community-based facilities. For their part, mental health professionals may readily acknowledge the need for a continuity of available care and even decry the fragmentation of mental health services, yet they may resist attempts by the courts to link the inpatient hospital services received by a respondent pending a commitment hearing with the outpatient services ordered by a court. Finally, community-based mental health workers may chide a commitment court for ordering services in the community for a respondent without considering their evaluation of the plans for those services, yet resist attempts by the court or the parties to a commitment proceeding to seek their help beforehand.

The adage "out of sight, out of mind" should not characterize the involvement of judges and attorneys with an involuntarily committed person. Unfortunately, such a characterization applies in many jurisdictions. Although the thinking of judges, attorneys, and mental health professionals about involuntary commitment has changed considerably since the 1950s, posthearing procedures are often conducted today as if (a) commitments are unalterable and practically indeterminate, (b) the facilities to which respondents are committed retain total control and authority over a respondent's well-being for a long time, (c) treatment plans are static and a respondent's condition is unchanging, and (d) coordination and cooperation of the various components of the mental health-judicial system are not needed. At the close of a hearing, lawyers are often dismissed. A respondent ordered to undergo treatment and care on an involuntary basis may not be seen or heard from until mandatory court review of commitment, when new lawyers, and perhaps a different judge, become involved with the case. Further, when there is little review and screening of cases before a court hearing — and the hearing is considered the centerpiece of the commitment process — the respondent's brief time in court becomes the practical be-

ginning and end of any safeguarding of his or her interests by the legal system. As addressed by the guidelines in Part B, this lack of continuity in the commitment process works to the detriment of not only the respondent but also the fairness, effectiveness, and the efficiency of the commitment process. The guidelines in this part encourage involvement of courts and lawyers in commitment cases beyond the point of a commitment hearing.[4]

Obviously, there are many issues that affect the lives of civilly committed persons that are not, in a technical sense, related to the process of involuntary civil commitment as defined by law. These issues include the rights of all mentally ill patients, including their general rights to a healthful and humane environment and their qualified rights as involuntary patients to determine the nature of their treatment; the "dumping" of previously institutionalized patients into communities unprepared to received them and unable to provide them with the services they require; the need for good treatment and care in decent local facilities; the fragmented voluntary and involuntary mental health system; the effects of budget cuts on community mental health centers; the decline of state hospitals; the growth of for-profit psychiatric hospitals and the emergence of a two-tiered system of mental health care, one for the affluent and one for the poor; and landlord-tenant disputes, marital problems, denial of social security disability benefits, and a host of other factors that may have implications for a respondent's ability to function.[5] Even the best involuntary civil commitment system, whereby good treatment and care is provided in local facilities staffed by competent professionals who respect the legal rights of involuntary patients and attend to the interests of their families and the community, cannot fully address these issues. There are a variety of complementary and related services, including patient advocacy, case management, and financial assistance, that are necessary for involuntary civil commitment to work well.[6]

These issues must be taken into consideration and recognized as impinging on the posthearing procedures of civil commitment. As important as these issues are, however, they can be merely acknowledged here.[7] The four guidelines in this part focus on a set of narrower issues more closely tied to the legal procedures of involuntary civil commitment after the hearing. The focus is on the roles of the attorney and the courts and their interactions with treatment and care providers. Guideline H1 delineates the duties of respondent's counsel after a civil commitment hearing has been concluded. Guideline H2 prescribes the development of a treatment plan and recommends that the plan be submitted for review by the court and, upon request by the parties, subjected to a judicial hearing. Guideline H3 prescribes procedures for unconditional discharge and conditional release of a respondent from involuntary care. Finally, Guideline H4 deals with the vexing issues surrounding the monitoring and supervision of involuntary patients in community settings.

Notes

1. For a discussion of the least-restrictive-alternative doctrine, *see* Commentary, Guideline G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment." *See also* R. Reisner, *Law and the Mental Health System* 390 (1985).

2. *See* Commentary, Guideline G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment."

3. *See* S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* 208-13 (3d ed. 1985).

4. *But see* Appelbaum, *The Rising Tide of Patients' Rights Advocacy*, 37 Hosp. & Community Psychiatry 6 (1986) (warning that legal advocacy programs should not be viewed as a substitute for adequate funding of mental health services).

5. *See generally* S. Brakel, J. Parry, & B. Weiner, *supra* note 3.

6. "In an atmosphere of sufficient resources, advocates and mental health professionals can work together and identify and meet the needs of patients." Appelbaum, *supra* note 4, at 10.

7. For a discusssion of these issues, *see* S. Brakel, J. Parry, & B. Weiner, *supra* note 3; R. Reisner, *supra* note 1.

H1. Posthearing Duties of Respondent's Counsel

Because the consequences of commitment do not cease once a court orders involuntary civil commitment, and because an attorney who has represented a respondent preceding and during a court hearing has usually acquired a good working knowledge of the case, that same attorney, ideally, should main-tain responsibility for the respondent's legal representation so long as the respondent remains an involuntary patient. If the attorney representing the respondent during the commitment proceedings does not continue to represent the respondent after involuntary civil commitment, he or she nonetheless should assure that the respondent is represented in all matters that stem from the respondent's com-mitment.

Consistent with the role of an advocate and advisor that a respondent's attorney is encouraged to assume by Guideline E2, the attorney with continuing responsibility for the case (or, alternatively, the attorney to whom that responsibility has been assigned following commitment) should be available to confer with and represent the interests of the respondent not only in contesting his or her commitment but also in making the necessary arrangements with treatment and social service providers to assure that he or she receives the best possible treatment consistent with the purposes of commitment.

Commentary

Guideline H1 places responsibilities on the respondent's legal counsel, in addition to those before and during a judicial hearing, for assuring that a respondent is well represented after a court has involuntarily committed the respondent. Under many commitment schemes existing throughout the country today, the attorney assigned to

a commitment case may be the person in the best position to assume continuing oversight responsibility for the well-being of a respondent as he or she "moves" through the involuntary civil commitment process.[1] This does not mean that counsel necessarily knows something that the treatment providers do not. Obviously, attorneys cannot do what is required of them without the cooperation of many other individuals and agencies working together, e.g., the mental health screening officer who made the initial contact with the respondent, the mental health professionals who treated the respondent pending the outcome of the commitment hearing, the treatment providers and case managers assigned to the respondent's case, and advocates assigned to represent the respondent's interests in matters not directly related to involuntary civil commitment.

Under ideal conditions, attorneys may need to do little except represent the respondent at mandatory court hearings to review commitment and advance the respondent's legal interests in matters stemming from the adjudication of commitment. Matters of good treatment and care, as well as the protection of the respondent's rights only indirectly related to his or her commitment, would be fairly and expeditiously handled by other individuals and their agencies. However, given the reality of a fragmented system of involuntary mental health care, even assuming that each component of that system is as good as it can be, the respondent's legal counsel should help to assure that the respondent does not subsequently "fall through the cracks." Even well-intentioned treatment providers and advocates in hospitals, for example, may at times be unaware of services available to a respondent in the community, and mental health screening officers may lack the legal clout to back up requests for the conditional release of a respondent.

Duties performed by the respondent's attorney in the role of a broker (i.e., conferring with the respondent, service providers, and patient advocates and arranging for treatment and care) are among the most important actions that can be taken on behalf of a respondent after civil commitment. Although most attorneys may be unaccustomed to this role, if it is viewed as a logical extension of the type of prehearing legal representation prescribed by the guidelines in Part E, "Legal Representation," it need not overwhelm a well-motivated and diligent attorney. In some commitment cases, all that may be required of a respondent's attorney is to hold a conference with the respondent and the treatment providers and to make a few telephone calls to prompt actions on behalf of the respondent. Of course, the courts should provide appointed attorneys with appropriate compensation for these posthearing duties.

In cases in which it is difficult or impossible for a single attorney to carry a case through the entire commitment process (e.g., when a court formally dismisses an attorney from the case at the end of a commitment hearing or a respondent requests other counsel), the attorney is obligated to assure that the respondent is represented in all posthearing matters. One member of the National Task Force analogized the attorney's obligation to transfer responsibility for a case to another professional to a physician's obligation to either treat a patient for whom he or she has assumed responsibility or refer the patient elsewhere as may be appropriate.

Guideline H1 also seeks to ensure that all necessary legal remedies remain available to a respondent following a court's commitment order and that those remedies do not become unavailable because lack of legal representation. Attorneys should be thoroughly familiar with motions for amended findings, stays of the commitment order pending appeal, appeals, petitions for writ of *habeus corpus*, and other legal actions to contest commitment. Checks on the validity or appropriateness of a respondent's continued involuntary commitment may be achieved by formal or informal administrative review or by judicial review. Review may be mandatory or upon request of either the respondent or someone on his or her behalf, or upon request of an individual or agency seeking the respondent's confinement.

Appeal, Writ of Habeas Corpus, and Other Remedies

All states recognize a right of appeal in involuntary civil commitment cases. Provisions for appeal may be included specifically in a state's mental health code. Alternatively, the mental health code may state that an appeal may be taken in the same manner as in other civil cases.[2] The right to appeal is not specifically addressed in the mental health codes of at least two states.[3]

When specifically included in a mental health code, appeal provisions may delineate various considerations: who may appeal; what judicial body receives the appeal; what specific procedures initiate appeal; whether the appeal is on the record or *de novo*; if the appeal is *de novo*, whether there is a right to a jury; the specific timing of appeal; and, finally, provisions for release of the respondent pending appeal of his or her commitment.

All of the states recognize the right to petition for a writ of *habeas corpus*, challenging civil commitment. A writ of *habeas corpus* is a collateral attack on a previous judgment and is an extraordinary legal process typically used only when other remedies have proven unsuccessful. A writ of *habeas corpus* may be filed in a superior court, probate court, state appellate court, state supreme court, or in a federal court if state remedies have been exhausted.

Petitions for a writ of *habeas corpus* are rare, except in California, where several of the commitment routes have no recourse to a judicial hearing except by writ of *habeas corpus*. Upon receiving a petition for writ of *habeas corpus*, California courts must either release a respondent or order an evidentiary hearing to be held within two judicial days after the petition is filed. Writ of *habeas corpus* hearings are available upon request to

respondents "certified" for fourteen days of involuntary intensive treatment following an initial seventy-two-hour detention for emergency evaluation and treatment, to respondents posing an imminent suicide threat "recertified" for an additional fourteen days of treatment, and to respondents for whom a temporary conversatorship has been created.[4]

Some states provide formal and informal administrative remedies for contesting involuntary civil commitment. Mental health personnel may notice a remission of symptoms in the respondent and, on their own initiative, discharge the respondent. Alternatively, the patient may convince mental health personnel of symptom remission and, thereby, justify discharge. Finally, respondents may, within certain restrictions, request a conversion from involuntary to voluntary patient status.

Periodic Review Hearings

Most states require that protracted periods of involuntary commitment be subjected to periodic reviews to determine whether continued commitment is necessary and appropriate. Such reviews may be conducted by a judicial body or by the mental health facility administration. Administrative periodic reviews of all patients, regardless of status, are required in most states. In Massachusetts, for example, such reviews must occur at least once upon admission, once during the first three months of commitment, once during the second three months of commitment, and annually thereafter. Each review must include a clinical examination, a review of the patient's legal competency, and a consideration of alternative care and treatment.

State statutes generally provide judicial review procedures to extend commitment beyond the initial period authorized by commitment order.[5] Periodic review hearings are mandatory[6] or provided upon request of the respondent.[7] In Ohio, for example, a respondent has a right to mandatory periodic review of the initial commitment decision. Review must occur at the end of the first ninety days after the original commitment decision. Thereafter, review hearings must be held at least every two years, except that upon request, a respondent is entitled to a hearing every 180 days. At least ten days before the end of the initial ninety-day commitment, the applicant who sought the respondent's commitment or the head of the hospital must file with the court an application for continued commitment.[8]

For the most part, recommitment procedures are the same as those for the initial commitment. The burden of proof remains with the committing facility. The respondent retains the rights to counsel, to present independent testimony, and to proper notice.

Beyond periodic judicial reviews, however, the use of legal remedies against protracted involuntary commitment is relatively infrequent. The infrequency of appeals is not surprising. Appellate review is an extremely labor-intensive and time-consuming process. In today's era of relatively brief commitment periods, most respondents are released from involuntary hospitalization long before an appellate hearing could take place. Respondents who face protracted involuntary commitment are typically individuals in the most desperate need of inpatient treatment and care, a factor that may account for the infrequency of appeals. Also, if the respondent's case does not present legal reform issues and the respondent is discharged before the appellate hearing, the case may be dismissed as moot. Another factor that may account for the infrequency of appeals in some jurisdictions is the procedure of dismissing the respondent's counsel upon completion of the judicial hearing. Consequently, many attorneys are unfamiliar with the appeals process.

From the standpoint of economy and efficiency, appellate review and petitions for writ of *habeas corpus* may be much less attractive and workable options for the respondent's release than are other administrative remedies. A common option is for the respondent to apply for voluntary hospitalization. In most states the opportunity for voluntary admission is available to a respondent at any time, regardless of the length of time the respondent has already been involuntarily hospitalized.[9] The hospital must either discharge the respondent after his or her request for voluntary admission or file an affidavit with the court to hold the respondent in the hospital.

Appellate review and other remedies are important for the protection of involuntarily committed persons' liberty interests. Appellate review allows not only review of particular cases but, perhaps more importantly, also the settling of points of law interpreted differently by various commitment courts within a jurisdiction. In a field changing as rapidly as mental health law, it may be advisable to encourage development of case law clarifying ambiguous statutory provisions. In jurisdictions where appeals have been discouraged and where expedited appeals are not the common practice, statutory ambiguity and confusion may persist. If clarification is sought at all, it may be sought through repeated trips to the legislature, often a wasteful and exhausting process.

Notes

1. It is, of course, not difficult to envision systems whereby entities other than the assigned counsel assume oversight responsibility for the management of a respondent's case, from prehearing screening to postcommitment release and discharge planning, and oversee the gamut of care available to the respondent, including inpatient hospitalization. Such a system has been proposed in Virginia. Memorandum from the Virginia Association of Community Services Boards, Inc., to the Community Services Boards Executive Directors and Board Chairs, August 7, 1985.

2. *See, e.g.*, Ill. Ann. Stat. ch. 91 1/2, §3-816(a) (Smith-Hurd Supp. 1985); Mass. Gen. Laws Ann. ch. 123, §9(a) (West Supp. 1985); N.C. Gen. Stat. §122C-272 (Supp. 1985). *See* S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* 21-176 (3d ed. 1985).

3. N.J. Stat. Ann. §§30:4-34 to 30:4-44 (West 1981 & Supp.

1985); Ohio Rev. Code Ann. § 5122.15 (Page Supp. 1984) (noting that Ohio implies right by requiring a transcript and a record of the hearing).

4. Cal. Welf. & Inst. Code §§ 5241.1, 5262, 5275, 5308 (West 1984).

5. See Brakel, Parry, & Weiner, supra note 2, at 267.

6. *See, e.g.*, Ohio Rev. Code Ann. § 5122.15(H) (Page Supp. 1984); Idaho Code § 66-337 (Supp. 1985).

7. *See, e.g.*, Ind. Code Ann. § 16-14-9.1-10(g) (Burns Supp. 1985).

8. Ohio Rev. Code Ann. § 5122.15(H) (Page Supp. 1984).

9. *See* Brakel, Parry, & Weiner, *supra* note 2, at 189.

H2. Development and Submission of Treatment Plans

Once a commitment court has ordered compulsory care or treatment of a respondent, it should have reasonable assurances that a treatment plan has been developed by mental health and social services providers which is reasonably designed to achieve the ends sought in the commitment order.

(a) No more than ten days after a respondent has been found to meet the criteria for involuntary civil commitment, or within such shorter period as the court may prescribe, the agency or individual responsible for providing or coordinating services or treatment for the respondent should submit a treatment plan to the court. The court subsequently should provide copies of the plan to all parties.

(b) The treatment plan should be tailored to the respondent's needs. Standardized forms of a treatment plan should be avoided. The plan should include the following elements:

  (i) all assessments of the respondent's problems and needs;

  (ii) a brief description of the nature and effects of services and treatment already administered to the respondent;

  (iii) a description of services and treatment to be administered, their possible side effects, and feasible alternatives, if any;

  (iv) the identities of agencies and specific individuals who will in the future provide the services and treatment;

  (v) the settings in which the services and treatment will be provided;

  (vi) a timetable for attaining the goals or benefits of treatment or care to be administered; and

  (vii) a statement of the criteria for transition to less restrictive placements or for conditional or unconditional discharge from involuntary mental health services and treatment, as well as the date for transfer or discharge.

(c) The court should check that the treatment plan includes the elements outlined in paragraph (b) and that the plan accommodates the general requirements of the court's commitment order. The court should not be obligated to review the particulars of a treatment plan until formally requested by one of the parties.

(d) Any party should be entitled to request a court hearing to review the treatment plan and to subpoena treatment providers to testify at review hearings. The request should indicate the parts of the plan to be challenged. At the hearing, the court may approve, modify, or order revision of the treatment plan.

(e) In accordance with Guideline D6, "Prehearing Mental Health Treatment," treatment and care may be administered to the respondent prior to the court's approval, modification, or revision of the treatment plan.

Commentary

Guideline H2 calls for filing of a complete treatment plan with the court within ten days after the issuance of a commitment order. The plan is designed to inform all concerned of what services and treatment will be provided, how and where they will be delivered, by whom, approximately for how long, and why. It will inform the court if it is called upon to make postcommitment decisions. It also should help the respondent's attorney in his or her posthearing duties, as outlined in Guideline H1. It should be emphasized that the treatment plan and procedures recommended by Guideline H2 are not meant to supplant treatment plans and review procedures mandated by state statutes.[1]

Generally, the duty to provide good treatment to an involuntary patient falls to the mental health facility to which the respondent has been ordered. To the extent that there are deficiencies in the delivery of mental health services to the respondent, identifying those deficiencies should be considered the obligation of the facility and its internal quality review and control mechanisms.[2] Not only would it be very difficult for commitment courts to become involved in routine matters of quality control of involuntary mental health care, but also such involvement might have unintended, negative effects. For example, an extraordinarily comprehensive treatment plan ordered by a court for one respondent may be executed by a mental health facility at the expense of the care provided to other respondents.

The intent of Guideline H2 is not to place an unnecessary and onerous burden on mental health professionals by requiring them to develop treatment plans that may prompt requests for them to appear in court to argue the particulars of the plans. Instead, the guideline is meant to assist mental health professionals in articulating the components of a respondent's treatment and, thereby,

to give others, such as the respondent's attorney, a chance to review and react. The guideline is premised on the notion that the development of a treatment plan, no matter how fluid, and its communication to others can help a respondent's involuntary treatment and care.

The mental health facility or individual responsible for the respondent's care and treatment should prepare the plan. As in preliminary treatment plans prepared as a part of the prehearing examination (see Guideline D5, "Prehearing Examination Reports"), "boilerplate" provisions are inimical to achieving truly individualized treatment and should be avoided.

Without an opportunity for review and the possibility of challenge, preparation of a treatment plan can easily become a meaningless ritual and an additional onerous task to be performed by overtaxed clinicians, rather than an effective technique for ensuring that respondents are provided appropriate services. Accordingly, paragraph (d) urges that the parties be entitled to present evidence supporting or questioning treatment plans and that the court, if requested, accept the responsibility for approving, modifying, or ordering revision of the plan. Ideally, the questioning and challenging of a particular treatment plan by the respondent's attorney or by other interested individuals should be done, at least initially, on an informal basis and in a manner that is constructive rather than confrontational and divisive. The intent of the guideline is not to substitute legal for medical expertise in making treatment decisions. Rather, it is to provide a mechanism for resolving disputes, protecting rights, and ensuring that responsibilities consequent to the commitment decision are met. Without a formal request for a judicial review of the treatment plan, a court's attention should be focused only upon the restrictiveness of the proposed setting and the general plan for treatment. The provision for court review should not imply that any change in the services, treatment, and setting prescribed in the plan requires prior judicial authorization. If a party petitions for judicial review of a treatment decision, however, the court should have the authority to modify or expedite implementation of the treatment plan.

A record of a respondent's care and treatment is crucial information in a treatment plan. At issue is not only the commitment per se but also the treatment and care recently provided the respondent and the extent to which he or she is benefiting from them. At the initial hearing, the court's deliberations of treatment and placement of the respondent into the most appropriate treatment setting are often largely a matter of conjecture, given the brief time the respondent may have been confined and the limited factual information the court can draw upon. Given a period of treatment history, however, responsible individuals have the opportunity to test the validity and appropriateness of continued commitment based upon specific aspects of past treatment.

A few states require the preparation of an individualized treatment plan. Of these states, a few specify the topics to be addressed in the plan.[3] Most states merely call for its preparation.[4] In Chicago, project staff observed that the preliminary plans tended to be brief and general, but that preliminary reports prompted a dialogue between attorneys and hospital staff about treatment choices. Further, preliminary plans helped to educate lawyers and judges about the types of treatment available in the hospitals, the time periods in which treatments might be effective, and the benefits that could be expected from these treatment modalities.[5]

Preparation of an individual treatment plan can serve several purposes. First, it can help to clarify the treatment goals for the respondent, his or her attorney, the treatment staff, and others. Second, it can provide a vehicle for exploring the various means of achieving these goals. Third, it can provide an estimate of the period of time required for treatment. Finally, a plan can define the services the respondent should expect to receive, how treatment staff will deliver the services, and what obligations the respondent has in the treatment plan. The plan can facilitate judicial review of petitions concerning treatment, and can facilitate the treatment itself.

From the perspective of the trier of fact during a judicial hearing, an individualized treatment plan structured to address the dispositional issues before the court can assist the determination of the appropriate course of treatment, ensuring that less restrictive alternatives are explored, clarifying the treatment to be provided, and facilitating subsequent judicial monitoring and review.

Although it would be desirable to have a full treatment plan available at the dispositional phase of the commitment hearing, it is unrealistic to expect treatment providers to prepare a full plan for each respondent in the brief period between the submission of a commitment petition and the hearing.[6] This leaves two alternatives, given the court's need for some guidance in framing a dispositional order. The first is the procedure used in Illinois, requiring that, prior to the hearing, the individual responsible for coordinating treatment submit information on alternative settings, the results of a social investigation of the respondent, and a preliminary treatment plan. A full plan must then be filed within thirty days after the hearing.[7] The second option is to delay the dispositional portion of the commitment process, at the respondent's request, to permit preparation of the plan. This option might be appropriate primarily in those rare, nonemergency cases in which immediate and continuous treatment is unnecessary and the respondent is allowed to be free of coercive intervention pending the preparation of the plan. However, this option has the disadvantage of misusing the hospital as a place for custody rather than treatment.

If certain safeguards are in place, the first option should permit the court to make an informed decision

without unduly burdening or delaying the process. Safeguards include permitting the respondent to obtain an independent examiner, at state expense if the respondent is indigent; requiring that the treatment plan be truly individualized; providing the respondent with an opportunity to participate in the preparation of, and to challenge, both the preliminary and the full treatment plans; authorizing the court to require submission of the full treatment plan; and providing for a formal hearing on that plan if requested by the parties.

Notes

1. *See* Commentary, Guideline H1, "Posthearing Duties of Respondent's Counsel."

2. *See* Appelbaum, *The Rising Tide of Patients' Rights Advocacy*, 37 Hosp. & Community Psychiatry 9 (1985).

> Although the rooting out of physical abuse and negligent treatment of patients was once thought to be an integral part of the provision of care, and thus the responsibility of the mental health system itself, the new emphasis on external advocacy contains an implicit concession that there is little hope that the mental health system, whether public or private, can offer appropriate care without tight external supervision.

Id. at 10.

3. *See, e.g.*, Ill. Ann. Stat. ch. 91 1/2, § 3-810 (Smith-Hurd Supp. 1985).

4. *See, e.g.*, Ind. Code Ann. § 16-14-9.1-10(e) (Burns Supp. 1985); N.M. Stat. Ann § 43-1-12.A (1984); N.C. Gen. Stat. § 122C-57(a) (Supp. 1985). Of the states requiring treatment personnel to submit an individualized treatment plan to the court, most indicate that preparation of the full plan should follow the commitment hearing. E.g., Ind. Code Ann. § 16-14-9.1-10(e) (Burns Supp. 1985); Mich Comp. Laws Ann. § 330.1712 (West 1980); N.M. Stat. Ann. § 43-1-12.A (1984). A few states, however, specify that a preliminary or proposed plan be submitted in time for the court to consider it at the hearing. E.g., Ill. Ann. Stat. ch. 91 1/2, § 3-810 (Smith-Hurd Supp. 1985).

5. Van Duizend & Zimmerman, *The Involuntary Civil Commitment Process in Chicago: Practices and Procedures*, De Paul L. Rev. 225, 264 (1984).

6. *See id.*

7. Ill. Ann. Stat. ch. 91 1/2, §§3-810, 3-814 (Smith-Hurd Supp. 1985).

H3. Unconditional and Conditional Releases from Commitment

Even with the best of involuntary mental health care available, it is unlikely that more than a few respondents will complete totally a course of recommended treatment during the period of court-ordered outpatient or inpatient treatment and care. Most will be in need of continuing mental health care and related social services. Therefore, the mental health facility charged with providing involuntary mental health services has an obligation not only to release unconditionally or conditionally, as may be appropriate, any respondent who no longer requires the type or level of involuntary care provided by that facility but also to plan that release in accordance with good mental health practices, *viz.*, not merely to "dump" an unprepared respondent into an environment unprepared to accept him or her.

(a) At any time during a period of court-ordered commitment to an inpatient or outpatient mental health facility, a respondent should be released unconditionally from civil commitment if the individual(s) responsible for the respondent's treatment and care feel that he or she is no longer a fit subject for involuntary mental health services.

(b) If, at any time during a period of court-ordered commitment to an inpatient or outpatient mental health facility, a respondent's condition improves but the respondent remains in need of involuntary mental health services less restrictive than those provided by the facility, the individual(s) responsible for the respondent's care should effect a transfer to a less restrictive facility or a conditional release of the respondent, which may include outpatient treatment and care or a combination of outpatient and inpatient treatment and care.

(c) Release of respondents from commitment, whether conditional or unconditional, should be accomplished with a discharge or "after care" plan. This plan should be prepared and submitted to the court prior to the patient's discharge. It may be reviewed and challenged by any of the parties. Discharge should not require prior court approval, however.

Commentary

Fifteen years ago it may have been true that it was too difficult to cause a respondent's release from an institution. Today, the opposite may be true. Involuntary patients may be released too early, still "warm" with symptoms of severe mental illness and unprepared to live outside of an unstructured, unsupervised environment. Guideline H3 provides a mechanism to prevent premature release and "dumping" of patients into the community without adequate mental health and related social services.

Guideline H3 also provides a measure of protection for family members and the community upon the release of a respondent who may have been committed on the basis of dangerousness to others. By the requirement that plans for the unconditional or conditional release of a respondent to be filed with the court, parties wishing to contest the respondent's release are given the opportunity to do so. However, the guideline does not require prior court approval of a respondent's release, regardless of the basis of his or her original commitment. Except when there is a court order to the contrary, mental health authorities charged with the respondent's involuntary mental health

care retain the authority to effect a respondent's unconditional or conditional release from involuntary mental health services.

Guideline H3 is in keeping with the need for linking what might otherwise be fragmented human services. By requiring plans for preparing both the respondent and the environment for the respondent's release, it recognizes that the goals of involuntary civil commitment do not abruptly become irrelevant at the time a respondent leaves a particular facility.

Paragraphs (a) and (b) give mental health facilities the authority to release a respondent, with or without conditions, if the individuals responsible for the respondent's involuntary mental health care feel that such release is warranted. Most states already give responsible mental health officials this authority as a matter of law.[1] Paragraph (c) prescribes a mechanism whereby the respondent is prepared for his or her transition to the community and outpatient treatment and care and the community can be prepared, if necessary, for the respondent's release. Notice of the respondent's unconditional or conditional release is provided by means of the discharge plan filed with the court. The discharge plan and the opportunity to review and contest that plan serve the interests of the respondent, the petitioner, and the state. Review of the plan provides a respondent's attorney with the opportunity to ascertain whether the mental health facility releasing the respondent has met its obligation to plan adequate transitional services and case management. As part of his or her posthearing duties, the respondent's attorney is encouraged to confer with the respondent regarding the discharge plan and, on an informal basis, convey to the treatment providers any concerns and wishes that the respondent may have regarding his or her release. The respondent's attorney should work cooperatively with the treatment providers to make the necessary arrangements consistent with the respondent's needs and wishes. The respondent's attorney may request a court hearing to review the discharge plan.

In formulating Guideline H3, the National Task Force acknowledged that the issue of the judicial involvement in release decisions made by mental health authorities, especially in cases where a respondent was committed on the basis of dangerousness to others, is a complex and vexing one. Several members of the National Task Force noted that judicial involvement in release decisions could cut both ways for a respondent. On the one hand, mandatory judicial review and approval of release decisions may impede appropriate release and undermine sound clinical judgments. On the other hand, hospital staff may be reluctant to release a respondent committed on the basis of dangerousness to others solely because of fear of liability or adverse publicity stemming from the respondent's release. In such instances, court approval of release decisions by hospital staff may indeed expedite a respondent's release.

Many respondents released from hospitals do not need continued outpatient care and treatment. However, some may clearly benefit from outpatient treatment while living in community mental health care facilities or with families and friends. Unfortunately, many patients are simply "transinstitutionalized," finding their ways into jails, prisons, and locked wards of nursing homes, where conditions may be far worse than in the hospitals from which they were released.2 The appropriateness of the environment into which the respondent is released depends, of course, not only upon the availability of appropriate, less restrictive therapeutic settings but also upon the cooperation between mental health care facilities, especially hospitals and community-based facilities.[3]

Notes

1. Arizona's Mental Health Services Act gives partial statutory expression to Guideline H3. Ariz. Rev. Stat. Ann. § 36-540.01.A. (Supp. 1975-1984). *See also* Alaska Stat. § 47.30.795 (1984). The medical director of a mental health care facility in Arizona may pursue conditional outpatient treatment for any respondent ordered to undergo inpatient treatment if he or she determines with a reasonable degree of medical probability that the respondent (a) no longer requires continuous hospitalization, (b) will be more appropriately treated on an outpatient basis, (c) is likely to follow a prescribed outpatient treatment plan, and (d) is not likely to become dangerous or suffer serious physical harm or serious illness if he or she follows the prescribed outpatient treatment plan. An objection frequently asserted against involuntary outpatient commitment is that a respondent's participation and cooperation in a treatment program less restrictive than hospitalization cannot be ensured. The Arizona statute apparently counters this objection by providing for notice to interested parties of the respondent's conditional outpatient treatment program, review of the respondent ordered to undergo the program, and procedures for amending or rescinding the order for conditional outpatient care.

Before conditionally releasing a respondent previously found to be dangerous to *others*, the medical director must give notice to the court and any other persons with a legitimate reason for receiving such a notice in order to provide the opportunity for the filing of a motion with the court to determine whether the standard for conditional release has been met. At least every thirty days, the medical director must receive a report about, and review the condition of, a respondent on conditional outpatient treatment and enter his or her findings in the respondent's file. The medical director may amend any part of the outpatient treatment plan or rescind the order for conditional outpatient treatment altogether and order the respondent returned to an inpatient treatment program. The medical director is not civilly liable for any act committed by a respondent undergoing conditional outpatient treatment if the medical director has adhered in good faith to the requirements for conditional outpatient treatment and care.

2. Stromberg & Stone, *A Model State Law on Civil Commitment of the Mentally Ill*, in American Psychiatric Association, *Issues in Forensic Psychiatry* 57, 61 (1984).

3. In Williamsburg-James City County, Virginia, cooperation between the inpatient facility, Eastern State Hospital, and the community mental health center is apparently high. Plans for a respondent's discharge begin immediately upon his or her admission to Eastern State Hospital. The hospital assigns the respondent a treatment team composed of a psychiatrist, a psychiatric resident, a psychologist, a social worker, a nurse, and other appropriate staff persons. The treatment team convenes an "evaluation, planning, and discharge" conference shortly after the respondent is admitted to the hospital. The hospital and the local community mental health center have negotiated "discharge" agreements describing the responsibilities of each agency for planning and following up on the respondent's discharge from the hospital. A case manager of the community mental health center regularly attends the conferences on behalf of clients from the geographical area served by the community mental health center.

To both reduce its patient population and enhance successful transitions from hospital to community, Eastern State Hospital has developed the Community Support Services Program. The program began in early 1982 with the assistance of community mental health centers. Its primary mission was to create appropriate placements for patients who, because of long periods of hospitalization, would find moving back into the community very difficult. Institute on Mental Disability and the Law, *A Model for the Application of the Least Restrictive Alternative Doctrine in Involuntary Civil Commitment: Final Report of the Least Restrictive Alternative Project* 222-26 (1984).

An effective transitional program has also been in use in the Bronx, New York. Under this program, groups of six to eight adult inpatients are formed within the hospital to undergo two- to four-month predischarge treatment in preparation for joint discharge and placement in community residences. During this time, the patients live in a transitional, open ward and participate in group and individual therapy, community visits, and vocational training. After discharge, the patients live together in apartments and are supervised by community agencies. The ultimate goal of the group resettlement program is integration into the community and independent living. *See* Stastny, *A Comprehensive Group Resettlement Program for Psychiatric Inpatients* (no date).

H4. Monitoring, Review, and Revocation of Involuntary Outpatient Status

Involuntary outpatient commitment of a respondent, ordered by a court in lieu of hospitalization, and conditional release, authorized by hospital staff after a period of hospitalization, are procedures consistent with the least-restrictive-alternative doctrine. The doctrine requires that a respondent's involuntary treatment and care be no more harsh, hazardous, intrusive, or restrictive than necessary to achieve legitimate therapeutic aims while at the same time protecting the respondent and others from harm.

The obligation to consider dispositional alternatives to institutionalization and to effect involuntary outpatient commitment or conditional release is imposed on courts and mental health facilities by the laws of most states and, quite possibly, by the Constitution. Meeting this obligation in practice, however, requires the following: community-based facilities willing and able to accept involuntary outpatients; appropriate resources in the community to implement the prescribed program of treatment and care; adequate supervision of respondents on outpatient status; procedural mechanisms and resources for monitoring a respondent's compliance with the conditions imposed by involuntary outpatient commitment or with the terms of conditional release; fair and workable mechanisms for reviewing outpatient status and proving a respondent's unsuccessful participation in or noncompliance with a program of involuntary outpatient treatment and care; and, finally, procedures whereby a court or mental health facility could impose remedies for a respondent's noncompliance with the conditions or terms of an outpatient commitment order or conditional release.

Before ordering involuntary outpatient care and treatment and before effecting the conditional release of institutionalized respondents, courts and mental health facilities, together with attorneys, patients' advocates, families, and community coordinating councils, should be certain that these requirements are met. If they are not, there is no assurance that outpatient commitment ordered by a court and conditional release effected by inpatient hospitals are any different in nature and consequence than unconditional release.

Commentary

There are two main procedures whereby a respondent can leave or avoid involuntary hospitalization altogether, but yet be required to undergo compulsory mental health treatment or care. Their use hinges upon the respondent's compliance with certain conditions. The first is conditional release authorized by hospital staff after a period of hospitalization. A common condition of release is that the respondent receive treatment from a community mental health center. The concept of conditional release from an institution to provide a period of transition for appropriate patients is not new. Statutory provisions for conditional release exist today in most states.1 The second procedure, whereby a respondent can avoid institutionalization altogether, is involuntary outpatient commitment. Under this procedure, a respondent is ordered by a commitment court to receive compulsory treatment and care in the community in lieu of institutionalization.[2] Most states make either explicit or implicit provisions for involuntary outpatient commitment in their statutes.[3]

The main purpose of conditional release is to reintegrate the respondent into the community. The main purpose of involuntary outpatient commitment is to provide compulsory noninstitutional care for respondents who do not require hospitalization in the first place. Under both procedures, the respondent's outpatient status hinges on his or her compliance with conditions imposed by the court or mental health facility. The two procedures are civil analogues of criminal probation and parole. That is, the requirements for supervision, monitoring, and review of a respondent's outpatient status imposed by involuntary civil commitment and conditional release are comparable to those requirements for criminal probation and parole.[4] The criminal justice system has not had an easy time meeting these requirements.[5] It seems unlikely that the mental health-justice system will fare any better, especially if few resources are available to make outpatient commitment and conditional release actually work in the community.

Both involuntary outpatient commitment, which is ordered by a court in lieu of compulsory hospitalization, and conditional release, which is effected by hospital staff only after a period of compulsory hospitalization, are consistent with the guarantee of care and treatment in the least restrictive setting provided by most states.[6]

The proper supervision, monitoring, and review and the mechanisms for revocation of involuntary outpatient status — without which these two procedures are of little practical value — represent a relatively untested area of mental disability law and practice which is riddled by a number of vexing problems. These problems are in addition to those related to the accuracy and fairness of the initial decision made by a court or mental health official to order or authorize compulsory treatment and care, and they are in addition to those commonly associated with inadequate mental health resources and related social service available in the community.[7] Obviously, outpatient commitment and conditional release make no practical sense when appropriate community-based services are not available.

Some of the most difficult problems standing in the way of proper implementation of involuntary outpatient commitment and conditional release procedures relate to the supervision, monitoring, and review of respondents' oupatient status and the revocation of that status. Specifically, these problems include

(a) the lack of organizational structures, procedural mechanisms, and resources within the courts and the mental health system (comparable to those of the criminal probation and parole systems) for the supervision of outpatients and the monitoring of a respondent's compliance with an outpatient treatment plan authorized by a commitment court or hospital authorities;

(b) the lack of standards and procedural mechanisms for reviewing and for certifying a respondent's compliance with an outpatient treatment program; and

(c) the lack of procedural mechanisms whereby commitment courts and hospital authorities could impose sanctions or remedies for a respondent's noncompliance with a court order or with the terms of release from an institution.[8]

Without provisions and resources for supervising, monitoring, and reviewing a respondent's compliance with the conditions of outpatient commitment or conditional release and without provisions and resources to revoke outpatient status and pull the respondent back into more restrictive care, conditional release and outpatient commitment are nothing but a hope. Who does the monitoring and supervising? How? With what resources? When does a formal review take place? How does revocation take place? According to what standards? By what means?

Such questions have yet to be addressed adequately as a matter of law or practice in most jurisdictions.[9] In Part G, the National Task Force urged caution in the use of outpatient commitment.[10] There, the focus was on judicial action in authorizing compulsory outpatient care. Although it acknowledged the attractiveness of the concept of involuntary outpatient commitment, the National Task Force urged caution in using the provisions for outpatient commitment, because their success had not yet been proven in practice. Guideline H4 extends this caution beyond the court disposition to actions taken by courts, mental health authorities, and others after outpatient status of a respondent has been initiated. Specifically, Guideline H4 encourages the courts, mental health officials, and others involved with involuntary outpatients to make certain that a number of important prerequisites to meaningful involuntary outpatient commitment and conditional release are established before outpatient commitment and conditional release are used.

Notes

1. *See* S. Brakel, J. Parry, & B. Weiner, *The Mentally Disabled and the Law* 205-08 (3d ed. 1985). Statutory provisions for conditional release exist in forty states. *Id*. at table 4.3, cols. 7-9.

2. For a discussion of involuntary outpatient commitment, see Commentary, Guideline G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment."

3. *See* Keilitz & Hall, *State Statutes Governing Involuntary Outpatient Civil Commitment*, 9 Mental & Physical Disability L. Rep. 379 (1985).

4. Probation is a criminal sentence, imposed in lieu of imprisonment, releasing a person convicted of a crime into the community under the supervision of a probation officer. Parole consitutes a conditional release of a prisoner (usually under the supervision of a parole officer) who has served part of the term for which he or she was sentenced to prison. Probation and parole may be revoked if the offender fails to observe the conditions provided in the court order or parole order. Like outpatient civil commitment, probation relates to judicial action taken *before* the prison door is shut, whereas parole, like conditional release from hospitalization, relates to executive action taken *after* the prison door has closed on a convict. *See generally* R. Dawson, *Sentencing* (1969).

5. *See* J. Petersilia, S. Kahan, & J. Peterson, *Granting Felons Probation: Public Risks and Alternatives* (1985); *Probation and Justice: Reconsideration of Mission* (P. McAnany, D. Thomson, & D. Fogel ed. 1984); J. Schmidt, *Demystifying Parole* (1977); A. VonHirsch, *Doing Justice* (1976).

6. *See* Lyon, Levine, & Zussman, *Patient's Bill of Rights: A Survey of State Statutes*, 6 Mental & Physical Disability L. Rep. 178 (1982); Keilitz, Conn & Giampetro, *Least Restrictive Treatment of Involuntary Patients: Translating Concepts into Practice*, 29 St. Louis U. L. J. Rev. 691 (1985). *See also* Commentary, Guideline G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment."

7. These problems are also in addition to those discussed in Guidelines G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment," and H3, "Unconditional and Conditional Releases from Commitment," associated with the courts' authority over community facilities, including (a) uncertainties about whether local laws authorize court orders to involuntary mental health services in the community and (b) serious questions of policy and practice regarding whether community-based mental health facilities and programs are obligated by law to accept involuntary patients ordered to undergo outpatient treatment by a court or conditionally released from an inpatient hospital.

8. Thirteen of twenty-seven states that explicitly authorize involuntary outpatient commitment have neglected to enact compliance monitoring and revocation procedures. These states have authorized a procedure with little chance of being used and, if used, little chance of being successful. Without effective revocation mechanisms, involuntary outpatient commitment is indistinguishable

from outright release and the hope that a respondent would seek outpatient treatment voluntarily.

Nine of the states with explicit outpatient revocation statutes have enacted procedures that are administratively indistinguishable from that of *voluntary* outpatient treatment. All require notice to the commitment court of treatment plan violations. In these nine states, however, the court is required to schedule a supplemental hearing to determine the cause of noncompliance and to consider modifications to the original order. Most of the states in this subgroup require notice and administrative procedures equivalent to the original hearing. Hawaii and North Carolina require the involuntary commitment process be initiated *de novo*.

The Oklahoma statute attempts to balance involuntarily committed outpatients' civil liberty interests with the establishment of procedures sufficient to ensure efficient functioning of the involuntary outpatient commitment alternative. The court is given discretionary power to issue an *ex parte* order to hospitalize the patient or, alternatively, to modify or rescind the original order. Within five days of the modification order, a hearing is held with procedural safeguards similar to those present in the original hearing. The patient is afforded an opportunity to show cause why the modification order should be rescinded.

Only six states permit modifications, including hospitalization, without requiring a supplemental hearing. Modification orders are presumably based upon the court record, the patient's medical records, the affidavits and recommendations of the medical director, and the advice and suggestions of staff and physicians providing involuntary outpatient commitment treatment. Arizona is typical of these states in that the maximum period of involuntary treatment is determined from the original adjudication date. The patient's liberty interests are not restricted, therefore, beyond the date determined at the original proceedings. Arizona's statute is unique in that it requires patients be notified of their right to petition the court for early release. *See* Keilitz & Hall, *supra* note 3, at 380-97.

9. For a general discussion of difficulties associated with conditional release, *see* Brakel, Parry, & Weiner, *supra* note 1. With regard to problems associated with involuntary outpatient commitment, *see* Bleicher, *Compulsory Community Care for the Mentally Ill*, 16 Cleve.-Mar. L. Rev. 93 (1967); Miller & Fiddleman, *Outpatient Commitment: Treatment in the Least Restrictive Environment?* 35 Hosp. & Community Psychiatry 147 (1984); Hiday & Goodman, *The Least Restrictive Alternative to Involuntary Hospitalization, Outpatient Commitment: Its Use and Effectiveness*, 10 J. Psychiatry & L. 81 (1982); Miller, *Commitment to Outpatient Treatment: A National Survey*, 36 Hosp. & Community Psychiatry 265 (1985); Myers, *Involuntary Civil Commitment of the Mentally Ill: A System in Need of Change*, 29 Vill. L. Rev. 403 (1984).

10. Guideline G2, "Consideration of All Dispositional Alternatives, Including Outpatient Commitment."

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